Institute for Women's Health and Body

Patient Update Information

(PLEASE Print Legibly-All information is Strictly Confidential)

Date: _______________ Patient Name: ____ DOB: _______________

Street Address: _________________________________ City: _________________________________ State: _____ Zip: _________

Home Phone: ___________________Cell Phone: _______________________ Email: ____

Marital Status: __________ Spouse Name: __________________________________ Contact Phone: _________________________

Emergency Contact: ____Phone:__________________________

Employer: __________________________ Occupation: _______________________ Business Phone: __________________________

Pharmacy: ______________________________ Location: ____________________________ Phone: _________________________

Primary Care Physician: ____ Phone: _________________________

Who is financially responsible for this bill? ___________________________________ Relationship to you: ____________________

Address if different then your own: ____ Phone: _________________________

Please present insurance cards: Insurance Company (Primary): ___________________________

Insurance Company (Secondary): ___________________________

ASSIGNMENT OF INSURANCE

I hereby authorize the payment of benefits of my insurance policy, if any, to be paid directly to The Institute for Women's Health and Body for the services rendered by any of its employees.

I further authorize the release of any medical information required by my insurance company.

I understand that I am financially responsible for charges not paid by my insurance company. I also agree to be responsible for any charges incurred in the collection of this account, should I default from payment. Such charges include, but are not limited to, legal fees, collection fees or late charges.

I certify that the above information is true and correct to the best of my knowledge.

Signature____ Date____________________