Suburban Women's Specialists, LLC

Patient Information

NAME(Last, First, Middle)	BIRTHDATE	AGE	SSN

LOCAL ADDRESS	CITY	STATE	ZIP

HOME PHONE	CELL PHONE	FAX	CIRCLE PRIMARY PHONE CONTACT
			HOME CELL WORK

MARITAL STATUS	PCP Name	Pharmacy Name and Phone Number

EMPLOYER	FAX
ADDRESS	WORK PHONE

RESPONSIBLE PARTY INFORMATION (if different than above)

NAME(Last, First, Middle)	BIRTHDATE	SSN

LOCAL ADDRESS	CITY	STATE	ZIP

HOME PHONE	DAY PHONE	RELATIONSHIP TO PATIENT

PRIMARY INSURANCE		**SECONDARY INSURANCE(if applicable)**
NAME OF INSURANCE COMPANY		NAME OF INSURANCE COMPANY
NAME OF POLICY HOLDER	DOB	NAME OF POLICY HOLDER

Person(s) Suburban Women's Specialists representative may relate your health information to:

Name(s)	Relationship	Phone Number(s)

May we leave normal lab/radiology reports on your answering machine, or to whom answers the phone? Y / N
If YES, which phone number may we use? Home Cell Work (Circle if applicable)

Who may we thank for referring you to our practice?

I request that payment of medicare or other insurance company benefits be made to Suburban Women's Specialists, LLC for services provided. I authorize the release of any information needed for processing of this or a related claim. I will permit a copy of the authorization to be used in place of the original, and request payment of medical insurance benefits to the party who accepts assignment. I understand that laboratory studies, pathology studies and cultures sent out will be billed by the specific laboratories to myself and/or my insurance. I accept payment responsiblities if my insurance refuses to pay. **Our office provides estimates which allow you to better understand how much you will need to pay for specific health service(s). It is only an estimate and it is not a guarantee of coverage or payment. The final amount that you will owe may change for a variety of reasons including: (1) the benefits change, (2) the coverage ends, (3) there are other claims processed before these services are received, (4) fewer, more, or different services are received, or (5) the out-of-pocket maximum (when the plan starts to pay 100% for covered services), has been met.** ***Please note we DO NOT accept Medicaid and cannot bill Medicaid for any services rendered.***

I UNDERSTAND THAT MY SIGNATURE IS MY AUTHORIZATION

SIGNATURE OF PATIENT/GUARDIAN

DATE