

NORTHWEST WOMEN'S CONSULTANTS, S.C.
CONFIDENTIAL

A copy of your insurance card is necessary for your file

PATIENT INFORMATION

Please Print

Name _____
Last First Middle

Single Married Divorced Widowed Separated Email Address _____

Address _____
City State Zip

Home Phone () _____ Work Phone () _____ Cell Phone () _____

Date of Birth _____ Age _____ Social Security # _____

Employers Name & Address _____ Occupation _____

SPOUSE / PARENT INFORMATION

Spouse / Parent Name _____ Date of Birth _____ Social Security # _____

Employer _____ Work Phone () _____ Cell Phone () _____

INSURANCE INFORMATION

Primary Policy Holder's Name _____ Date of Birth _____ Insurance Co. _____

Secondary Policy Holder's Name _____ Date of Birth _____ Insurance Co. _____

OUR POLICY DOES NOT ALLOW US TO CHANGE THE DIAGNOSIS OR SERVICES AFTER THEY HAVE BEEN BILLED TO YOUR INSURANCE COMPANY.

I hereby authorize Northwest Women's Consultants S.C. to furnish information to insurance carriers concerning my illnesses and treatments and I hereby assign to the doctor all payments for medical services rendered to myself or my dependents. **I understand that I am responsible for any amount not covered by insurance.**

Confidential Communication

I hereby request **Northwest Women's Consultants, S.C.**, to keep communications regarding my **protected health information** confidential.

You can contact me by phone at: _____ with lab results.

Can we leave a **DETAILED** message with **NORMAL** results on answering machine and/or voice mail? Yes No

Can we leave a message that our office called with another person or answering machine? Yes No

With whom? _____

A copy of the Privacy Act is available at the front desk upon request.

Signature _____ Date _____
(Parent, if minor)