PATIENT INFORMATION

First Name: MI: Last Name:

DOB: / / Sex: M / F Marital Status: S / M / W / D

Street: APT: City:

ST: Zip: Cell#:( ) - Work#:( ) -

SSNo: - - Driver's License#: Issue ST:

If Student, Full / Part Time School:

PCP/Refer. Physician:

SPOUSE OR RESPONSIBLE PARTY INFORMATION

First Name: MI: Last Name:

DOB: / / Sex: M/F; Relationship to Patient:Self / Spouse / Dependent

Street: #: City: ST: Zip:

Home#:( ) - Cell#:( ) - Work#:( ) -

SSNo: - - Driver's License#: Issue ST:

Emergency Contact: Ph#:( ) -

PRIMARY INSURANCE INFORMATION

ID# GROUP# Insured's DOB: / /

INSURANCE CARRIER: Ph#:( ) -

Street: #: City: ST: Zip:

Insured's First Name: MI: Last Name:

Relationship to Patient:Self / Spouse / Dependent; SEX: M / F

Insured's SSNo: - - Work-Related Injury? Y / N;

DT of Injury: / / Reported to Employer? Y/N;

SECONDARY INSURANCE INFORMATION

I **do / do not** have secondary insurance coverage.

ID# GROUP# Insured's DOB: / /

INSURANCE CARRIER: Ph#:( ) -

Street: #: City: ST: Zip:

Insured's First Name: MI: Last Name:

Relationship to Patient:Self / Spouse / Dependent; SEX: M / F

SSNo: - -

CONTACT DATA

If it is necessary for us to contact you regarding lab results, medications, or other personal health information, please indicate the phone numbers we may use to contact you:
(1)( ) - (2)( ) - (3):( ) -

May we leave a message on your answering machine or voice mail
(1) at your home#? Y / N (2) at your work#? Y / N

AUTHORIZATION TO PAY INSURANCE BENEFITS

I hereby assign and authorize payment directly to Austin Women's Clinic the benefits otherwise payable to me, but not to exceed the physician's regular charges for services rendered. I understand that I am financially responsible to the physician for charges not covered by this authorization. I agree to pay deductibles if any, upon services rendered.

Patient's Signature:_____ Date:__/__/__

AUTHORIZATION TO RELEASE INFORMATION

I authorize Austin Women's Clinic to release to the above listed insurance companies protected health information necessary to process insurance claims for payment.

Patient's Signature:_____ Date:__/__/__

ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES, TESTING POLICY FOR ALCOHOL, DRUG AND HIV TESTING.

I have been advised of Austin Women's Clinic's Privacy Practices, which explain how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of this document.

I **received** a copy of the privacy practices, testing policy for Alcohol, Drug and HIV testing.

I **agree / disagree** to testing for Alcohol and Drug use as appropriate for my care.

I **agree / decline** to testing for HIV.

Patient's Signature:_____ Date:__/__/__