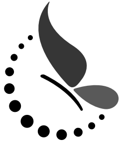

Information Update

Complete Entire Form and Sign at Bottom

Date: _______________ Date of Birth: _______________________

Name: ____

Address: ____

City: ______________________ State: ____________________ Zip: ________________

Mailing Address (if different from above):____

City: ______________________ State: ____________________ Zip: ________________

Email address: ____________________________________ Primary Phone: home or cell

Cell Phone Number: _____________________ Home Phone Number:____________________

Work Phone Number: ____________________

We need the name and address of your pharmacy.

Pharmacy Name: ____

Pharmacy phone number: ____

Pharmacy Address: ____

Assignment of Benefits
I hereby assign to Women Partners in OB/GYN any insurance or other third-party benefits available for health care services provided to me. I understand that Women Partners in OB/GYN has the right to refuse or accept assignment of such benefits. If these benefits are not assigned to Women Partners in OB/GYN, I agree to forward to Women Partners in OB/GYN all health insurance and other third-party payments that I receive for services rendered to me, immediately upon receipt. I understand that I am financially responsible for all charges whether or not they are covered by insurance.

Consent to Treat
I (or my legal guardian or parent) authorizes Women Partner in OB/GYN to provide medical care reasonable by today's standards. I understand that Women Partners uses electronic prescribing. My prescriptions may be sent and my medication information may be obtained through the electronic prescribing function

____________________________________ ____________________________

Signature of Patient/Legal Guardian Date