WOMEN PARTNERS
IN OB/GYN

Patient Information Sheet
Date:_____

Name: _____ Date of Birth:_____

Address: _____

City: _____ Zip: _____ Primary Phone: Home or Cell

Phone: Home _____ Cell _____ Work_____

Social Security No.: _____ Email:_____

Mailing Address:_____

Occupation:_____ Employer:_____

Preferred Pharmacy: _____

Pharmacy Phone Number: _____ Pharmacy Address: _____

In case of emergency please notify: Name: _____

Phone: _____ Relationship: _____

Primary Insurance: _____

Name of the Insured: _____ Date of Birth: _____ SSN: _____

Secondary Insurance: _____

Name of the Insured: _____ Date of Birth: _____ SSN: _____

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.

_____ _____

Signature of Patient/Legal Guardian Date

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