Women's Health Care of Warren, PA

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Name (Printed) ___________________________ Date of Birth___________ Age_____

Reason for today's visit: **Annual Exam** or **Other** If other, specify reason __________

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Date of last menstrual period ____

This form is divided into two sections. In the first section, we would like you to provide us with an update of your medical history. The second section provides information about patient rights and insurance coverage. Please read the attached document package and provide your acknowledgment of the information by signing below. Thank you.

SECTION 1
Patient Interval History

1. Have you had any menstrual problems since your last visit? ___________________
____
2. Have you had a hysterectomy? ____
3. Have you had any recent surgeries? What type? ____________________________
4. Do you have any allergies? ____
5. Are you currently on any medications? Please list. __________________________
____
____
6. Is there any family illness/history (whom?) that we should know about? __________
____

SECTION 2
Patient Rights and Insurance Coverage

❑ I have read and understand the **Office Policy Changes**. In particular, I have read the **In-Office/Lab Procedure Policy** and **the Pre-certification Policy**. My signature below indicates that **I AGREE** to have any necessary procedure that I have consented to. It also indicates that **I AGREE** to pay for any charges that my insurance may not cover.

❑ I have read and understand the **Consent to Use or Disclose Protected Health Information.**

❑ I have read and understand the **Notice of Privacy Practices Acknowledgment.** I am giving you my permission to leave messages on my voice mail/answering machine regarding my medical care.

____________________________________ ______________

Patient Signature Date

Women's Health Care of Warren

It is the patient's responsibility to provide all information requested. If any information is omitted or illegible, the patient will be billed directly and, will have to submit their claim to their insurance company.

Date:	Student: Yes No	Primary Care Physician's Name:
Patient's Name:		Primary Care Physician's Address: Phone Number:
Date of Birth:	Social Security Number:	Who will be responsible for payment: **Self / Parent / Other:________**

Patient Information

Home Address (Street):	Home Phone Number (including Area Code):
City: State: Zip Code:	E-mail Address:
Occupation:	Cell Phone Number (including Area Code): Carrier

Employment Information

Employed by:	City: State: Zip Code
Employer's Street Address:	Business Phone Number:

Primary Insurance Information		Secondary Insurance Information **(If different from Primary)**	
Name of insurance company:		Name of insurance company:	
Insurance Company Street Address:		Insurance Company Street Address:	
City State	Zip	City State	Zip
Subscriber ID #	Relationship to Patient	Subscriber ID #	Relationship to Patient
Group #	Group Name	Group #	Group Name
Name of primary policy holder:		Name of primary policy holder:	
Policy holder's date of birth:	Social Security Number:	Policy holder's date of birth:	Social Security Number:

In order to submit a claim for payment, we must have your authorization to release medical information to your insurance carrier.

* I hereby authorize Women's Health Care of Warren, PA to furnish information to insurance carriers concerning my illness and treatment.
* I also request payment of government benefits either to myself or to the party who accepts assignment below. I authorize payment of all medical benefits to Women's Health Care of Warren, PA for all medical services.
* I understand that some medical services may not be a covered benefit under my insurance policy (e.g. routine exams) and that I am financially responsible for all medical services not covered under my insurance contract.

Contact person in case of an emergency:	Telephone number:	Relationship to patient:

X________________________________ X____________________

Signature (denotes acceptance for all of the above) **Date**

New Credit Card Policy

I give Women's Health Care permission to bill the credit card I have left on file for any balance I have incurred which is 30 days or more past due. I understand that by giving this authorization, I will not incur any bill handling or late fees.

________________________________ ____________________

Credit Card Number **Type of Card** **Expiration Date & Code**

New Cancellation Policy

As of October 1, 2004, any patient who does not cancel their visit and fails to show up will be billed a $50 fee.