(PLEASE WRITE LEGIBLY AND COMPLETE FORM AS THIS IS A MEDICAL DOCUMENT)

Patient's Personal Information Marital Status: single married divorced widowed partnered

Name:_____ _____ _____
last first initial

Address: _____ Apt/Unit#_____ City:_____ State:_____ Zip: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Email:_____ Social Security #:_____ Date Of Birth:_____

What is your: Race_____ Ethnicity_____ What language do you primarily speak: _____

How you wish to be addressed (nickname) :_____

Preferred pronoun (Circle One) She He They Gender: Female Male Transgender _____

Name and Number of your Pharmacy:_____

Employer Name:_____ Occupation:_____

Policy Holder Information (person who carries insurance)

Policy Holders Name:_____ Date of Birth: _____

Relationship to Patient: Self Spouse Child Other_____ Social Security #:_____

Employer's Name:_____Work #:_____Cell #:_____

Primary Care Physician/ Referring Physician

Name:_____Address:_____Phone:_____

Emergency Contact (in case of emergency)

Name:_____Phone:_____Relationship:_____

Insurance Information (copy of insurance card)

Primary Insurance:_____
I.D.#_____Group#_____Copay_____

Secondary Insurance:_____
I.D.#_____Group#_____Copay_____

I understand and acknowledge that my Insurance coverage is a contract between me and my insurance company and that I am personally responsible for all medical expense incurred during evaluation and treatment by Women Caring for Women/All About Women's Care and their associates. I understand that as a courtesy my primary insurance will be billed however, it is my responsibility to follow up on delinquent claims. If I am a member of a PPO or a HMO I am required to make my co-pay and co-insurance payments in a timely fashion, and I am responsible for keeping my primary care referrals current.
I authorize All About Women's care and/or representatives to release all necessary medical information to my insurance carrier for processing my claims. I assign all benefits from said claims to All About Women's Care. I further agree that a photocopy of this agreement shall be as valid as the original.

Patient or responsible party:_____Date_____Relationship_____