WOMEN'S MEDICAL CENTER, P. C.

PLEASE PRINT Date: ______________

Name: ______________________________

Birth Date: ________________ Age: ______________

Social Sec. #: ____________________

Marital Status: ____S ____M ____W

Permanent Address: ______________________________

P.O. Box #: ____________ Apt.#: ____________

City: __________________ St: _____ Zip: ____________

Home Phone: ______________________________

Cell Phone: ______________________________

Email: ______________________________

Current Address: ______________________________

P.O. Box# ________________ Apt# ________________

City: ____________________ St: _______ Zip: __________

Preferred Language: English, Spanish, Other: __________

Race: (Please Circle)	**Ethnicity: (Please Circle)**
American Indian	Hispanic or Latino
Alaska Native	Not Hispanic or Latino
Asian	Unknown
Black or African American	
Native Hawaiian or Other	
Pacific Islander	
White	
Unknown	

Family Physician ______________________________

Employer: ______________________________

Work Phone: ______________________________

Permission to contact at work: (Please Circle) YES NO

Spouse's Name: ______________________________

Spouse's Phone: ______________________________

Spouse's Date of Birth: ______________________________

Spouse's Employer: ______________________________

MUST BE COMPLETELY FILLED OUT FOR HIPAA COMPLIANCE.

(1)Primary Insurance: ______________________________

Policy # ________________ Group # ______________

Policy holder's Relationship to Patient: ______________

Policy holder's Date of Birth: ______________________

Policy holder's Address: ______________________________

____

Effective Date: __________ Cancel Date: __________

(2)Secondary Insurance: ______________________

Policy # __________________ Group# ____________

Policy holder's Relationship to Patient: ______________

Policy holder's Date of Birth: ______________________

Policy holder's Address: ______________________________

____

Effective Date: __________ Cancel Date: __________

CANCELLED INSURANCE: ____________________

CANCEL DATE: ______________________________

BILLING INFORMATION FOR MINORS

Father's Name: ______________________________

Birth Date: ______________________________

Address: ______________________________

City: ______________ ST: ________ Zip: ____________

Phone: ______________________

Mother's Name: ______________________________

Birth Date: ______________________________

Address: ______________________________

City: ______________ ST: ________ Zip: ____________

Phone: ______________________________

INSURANCE AUTHORIZATION

I hereby assign, transfer, and set over to Women's Medical Center, P.C. all my rights, title, and interest to my medical reimbursement benefits under my insurance policy. I authorize the release of any medical information needed to determine these benefits. This authorization shall remain valid until written notice is given by me revoking said authorization. I understand that I am financially responsible for all charges whether or not they are covered by insurance.

Patient's Signature/Print Name: ______________________________ **Date:** ______________

Women's Medical Center, P.C.
1201 South Drive, Suite 220
Mt. Pleasant, Michigan 48858

Pharmacy Information:

Pharmacy Name: ____

Pharmacy Address: ____

Phone Number: ____

May we have permission to download your medication history from the pharmacy database to our medical records? **Circle one**: Yes No

Emergency Contact and Authorization for Disclosure of Medical Information

I, ______________________________ DOB: ____________, authorize Women's Medical Center, PC to contact in an emergency or release protected health information to the following person(s) as indicated:

Name	Phone Number	Relationship	Emergency Contact		Authorized to make medical decisions	
			YES	NO	YES	NO
			YES	NO	YES	NO
			YES	NO	YES	NO

I wish to be contacted in the following manner (check all that apply):

( ) Home Telephone: ____________________ Cell: ____________________
- ( ) OK to leave message with detailed information
- ( ) Leave message with call-back number only

( ) Written Communication
- ( ) OK to mail to my home address
- ( ) OK to mail to my work/office address
- ( ) OK to fax to this number: ______________

( ) Work Telephone: ____________________ ( ) Other__________________
- ( ) OK to leave message with detailed information
- ( ) Leave message with call-back number only

This release is effective until revoked. I understand that, as set forth in the practice's Notice of Privacy Practices, I have the right to revoke this authorization, in writing, at any time by sending written notification to the Privacy Officer at the address above. I understand that revocation is not effective to the extent that the practice has relied on the use or disclosure of the protected health information. I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law.

____ ________________

Signature of Patient or Personal Representative / Print Name **Date**