Lake Pointe Women's Centre

PATIENT INFORMATION:
Please print clearly and fill out completely: Primary Care Physician_____ Referred By_____

Name_____
First Middle Last

Address_____
Street Apt City State Zip

Primary Phone (___)_____(**Please circle)** Home/Work/Cell Secondary phone(___)_____(**Please circle)** Home/Work/Cell

Alternate Phone (___)_____**(Please circle)** Home/Work/Cell **E-Mail address:** _____

Date of Birth____/____/_____Age_____ Social Security #_____Driver License_____State___

Name of Employer_____Phone #(___)_____

Address_____City_____State_____Zip_____

Martial Status_____ Spouse/Significant Other's Name_____Phone Number(___)_____

Primary Insurance Information

Name of Insurance_____

Insurance Address for Claims_____City_____State_____Zip_____

Name of Insured_____ Relationship to Patient_____

Insured's Information:

Date of Birth___/____/____ Insured's Social Security #_____Member #_____Group #_____

Insured's Employer_____Phone #(___)_____

Insured's Employer Address_____City_____State_____Zip_____

Secondary Insurance Information

Name of Insurance_____

Insurance Address for Claims_____City_____State_____Zip_____

Name of Insured_____ Relationship to Patient_____

Insured's Information:

Date of Birth___/____/____ Insured's Social Security #_____Member #_____Group #_____

Insured's Employer_____Phone #(___)_____

Insured's Employer Address_____City_____State_____Zip_____

Nearest Friend or Relative Not Living With You (In case of an emergency)

Name_____Relationship to Patient_____

Address_____City_____State_____Zip_____

Home Phone (___)_____Business Phone(___)_____Pager(___)_____Mobile(___)_____

Assignment of Benefits

I hereby assign all medical and/or surgical benefits, to include major medical to which I am entitled, including Medicare, and other government sponsored programs, private insurance and any other health plan to Lake Pointe Women's Centre, PA. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges whether or not paid by said insurance. I hereby authorize said assignee to release all information to secure the payment.

Signature_____Date_____/_____/_____Account #_____