Lake Pointe Women's Centre

PATIENT INFORMATION FOR A MINOR:
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

Alternant Phone(___)_____**Please circle** Home/Work/Cell **E-mail:** _____

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

Parent or Legal Guardian's Name_____Date of Birth___/___/___Social Security #_____

Parent or Legal Guardian's Phone #'s: Home:(___)_____Work:(___)_____Mobile:(___)_____

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(___)_____Beeper(___)_____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 of Parent or Guardian:_____Date____/___/____ Account #_____