New Start Women's Care

PATIENT INFORMATION **___UPDATED INFORMATION**

Name_____DOB:_____SSN:_____

Address:_____City:_____State:_____Zip:_____

Home:_____n_____Celll:_____Work:_____

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Marital Status: M / D / S / W Occupation:_____

Emergency Contact:_____Relationship:_____Phone#:_____

Primary Care Physician:_____Phone#:_____

IF THE PATIENT IS A MINOR

Name of Parent or Legal Guardian:_____

Address:_____City:_____State:_____Zip:_____

Contact #:_____

Insurance # 1:_____ID#:_____Group#:_____

Subscriber's Name:_____DOB:_____SSN:_____

Insurance # 2:_____ID#:_____Group#:_____

Subscriber's Name:_____DOB:_____SSN:_____

Office use only

Eligibility date: Copay: $ Deductible: $ Met: $

*Please make sure the receptionist has your **current** insurance information such as insurance card, ID numbers, name of primary insured etc. Thank you.

Authorization: I hereby authorize physician to furnish information to insurance carriers concerning any illness/accident. I hereby irrevocably assign to the doctor all payments for medical services rendered. I understand that I am financially responsible for all charges whether or not covered by insurance.

_____

Signature Date

This office applies $25 charge to your account for NSF charges and missed appointments that are not cancelled 24 hours prior to the appointment time.