# Patient Demographics

***Please indicate below the preferred # to contact you, including location (i.e. Hm, Wk, Cell or other)***

#1________________________________ #2 __________________________________ #3 __________________________________

Name ___________________________________________________ DOB ___________________ SSN ______________________

Address ___________________________________________________ City _____________________ State ____ Zip _____________

Marital Status: Single _____ Married _____ Widowed _____ Separated _____ Divorced _____ Sex: Female _____ Male ____

Employer ____________________________________________________________ Occupation ______________________________

Business Address ______________________________________________________________________________________________

Whom may we thank for referring you? ________________________________________Referring Physician______________________

In case of an emergency who should be notified? ___________________________________________ Phone # ____________________

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***Responsible Party for Minors***

Name ___________________________________________________ DOB ___________________ SSN ______________________

Address __________________________________________________ City _____________________ State _____ Zip _____________

Primary Contact Number ________________________________ Secondary Contact Number __________________________________

Relationship to Patient _________________________Other Authorized Parents_______________________________________________

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***Primary Insurance Information***

Insured Party_____________________________________________ DOB ___________________ SSN ______________________

Relationship to Patient ___________________________________________________________ Phone # ______________________

Address __________________________________________________ City _____________________ State _____ Zip _____________

Employer ____________________________________________________________ Occupation ______________________________

Insurance Company ____________________________ Address __________________________________________________________

Member ID # _________________________________ Group # ___________________________ Phone # _________________________

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***Secondary Insurance Information***

Insured Party_____________________________________________ DOB ___________________ SSN ______________________

Relationship to Patient ___________________________________________________________ Phone # ______________________

Address ___________________________________________________ City _____________________ State _____ Zip ____________

Employer ____________________________________________________________ Occupation ______________________________

Insurance Company _____________________________ Address _________________________________________________________

Member ID # _________________________________ Group # ___________________________ Phone # _________________________

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***Assignment of Benefits and Financial Agreement***

I hereby give lifetime authorization for payment of insurance benefits to be made to **North Central Women's Health Partners** and any assisting physicians, for the services rendered. I understand that I am financially responsible for all charges whether or not they are covered by insurance. In the event of default, I agree to pay all costs of collection, and reasonable attorney fees. I hereby authorize this healthcare provider to release all information necessary to secure payment of benefits. I further agree that a photocopy of this agreement shall be as valid as the original.

Date ________________________________ Signature __________________________________________________________________