PARKWEST WOMEN'S HEALTH **PATIENT INFORMATION SHEET** **DATE:**

Name: First Middle Last DOB:

Address: Number Street City State Zip

Home Phone Work Phone Ext. Cell Phone

Email Address ☐ Print ☐ Phone Reminder Preference

Race: ☐ White ☐ Black ☐ Asian ☐ Pacific Islander ☐ Native American ☐ Other/Multiple

☐ Hispanic ☐ Non-Hispanic Marital Status: ☐ M ☐ D ☐ S ☐ W ☐ Partnered

Employer: Occupation:

Employer Address: Number Street City State Zip

Your Preferred Language: Spouse or Parent Name:

Spouse or Parent Employer: Name Address City State Zip

Person to contact in case of emergency:

Relationship to patient: Home Phone Work Phone Cell Phone

Referring/Primary Physician: Phone:

Address: Number Street City State Zip

Preferred Pharmacy: Phone:

Address: Number Street City State Zip

If referred by another patient, please list her name so that we can thank her

How did you hear about ParkWest? ☐ Patient ☐ Family ☐ Search Engine ☐ Web Site

INSURANCE INFORMATION

Primary Insurance: Effective Date of Coverage:

Address: Number Street City State Zip

Subscriber's (Policy Holder) Name: DOB: Relation to patient

Policy ID Number: Group Name/Number:

Policy Type: *(PPO, EPO, GOLD, SENIOR, ETC)* CO PAY AMOUNT

Secondary Insurance: Effective Date of Coverage:

Address: Number Street City State Zip Phone

Subscriber's (Policy Holder) Name: DOB: Relation to patient

Policy ID Number: Group Name/Number:

Policy Type: *(PPO, EPO, GOLD, SENIOR, ETC)* CO PAY AMOUNT

Patient Agreement and Authorization to Release Information

I, the undersigned, realize that Iam financially responsible for all services rendered to me by ParkWest Women's Health (the Practice).

For those insurance plans for which the Practice accepts assignment, I realize that I am personally responsible for all co-payments, deductibles and non-covered services, as dictated by my insurance coverage.

I authorize payment directly to the Practice for services for which the Practice accepts assignment.

I consent to have ParkWest Women's Health use and disclose my protected health information for payment, treatment and health care operations purposes and for such other purposes that are permitted under HIPAA without my written authorization.

I have had an opportunity to view ParkWest Women's Health's Privacy Policy and understand that I may request a paper copy.

I certify that the information stated on this form is correct.

Signature of Patient, Parent or Legal Guardian Date