

PARKWEST WOMEN'S HEALTH			PATIENT INFORMATION SHEET			DATE:			
Name:					DOB:				
	First	Middle	Last						
Address:									
	Number	Street		City	State	Zip			
Home Phone		Work Phone		Ext.	Cell Phone				
Email Address						<input type="checkbox"/> Print <input type="checkbox"/> Phone			
Race:		<input type="checkbox"/> White	<input type="checkbox"/> Black	<input type="checkbox"/> Asian	<input type="checkbox"/> Pacific Islander	<input type="checkbox"/> Native American	<input type="checkbox"/> Other/Multiple		
Occupation:			Marital Status:		<input type="checkbox"/> M	<input type="checkbox"/> D	<input type="checkbox"/> S	<input type="checkbox"/> W	<input type="checkbox"/> Partnered
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:		Address:			Phone:				
	Number	Street		City	State	Zip			
Preferred Pharmacy:		Address:			Phone:				
	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?				<input type="checkbox"/> Patient	<input type="checkbox"/> Family	<input type="checkbox"/> Search Engine	<input type="checkbox"/> 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:	CO PAY AMOUNT		DEDUCTIBLE AMOUNT	
		<i>(PPO, EPO, GOLD, SENIOR, ETC)</i>		
Secondary Insurance:		Effective Date of Coverage:		
Address:				Phone
	Number	Street	City	State Zip
Subscriber's (Policy Holder) Name:		DOB:		Relation to patient
Policy ID Number:	Group Name/Number:			
Policy Type:	CO PAY AMOUNT		DEDUCTIBLE AMOUNT	
		<i>(PPO, EPO, GOLD, SENIOR, ETC)</i>		

Patient Agreement and Authorization to Release Information

I, the undersigned, realize that I am 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