AVALON-A CENTER FOR WOMEN'S HEALTH

PATIENT DEMOGRAPHICS (PLEASE PRINT)

Name____
(first) (middle) (last)

Date of Birth ____________Marital Status ___________Social Security #__________________

Race__________ Ethnicity: Hispanic/Latino or NonHispanic/Latino Primary Language______________
(Circle One)

Address___________________________City__________________State_____Zip__________

Home # __________________Work # ___________________Cell #______________________

Email________________________ Pharmacy Name/Phone____________________________

REFERRING INFORMATION

Primary Care Physician____
(name & address, if possible)

Referring Physician (if different)____

How did you find out about the practice? Friend/Family_________________________________
(name & address)

Mailing ___________Newspaper ____________Yellow Pages _____________Internet__________________

INSURANCE INFORMATION

Patient Occupation_________________________________Fulltime__________Parttime________

Employer____
(name & address)

Name of Spouse/Parent ____________________________Cell Phone___________________
(name & address)

Home Address _____________________________________Home Phone________________
(if different from patient)

Employer_______________________________________ Work Phone_________________

Primary Insurance Company _______________________Policy Holder__________________

SS# ___________________DOB ________________Relation to Patient__________________

ID/Policy#____________________________Group#__________________________________

Secondary Insurance Company ____________________Policy Holder___________________

SS# _____________________DOB ________________Relation to Patient________________

ID/Policy#____________________________Group#__________________________________

CONTACT INFORMATION (In Case of Emergency)

Contact _________________________________Home Phone _________________________
(name & relationship)

Cell Phone _______________________ Work Phone _________________________________

Private Insurance Authorization for Assignment of Benefits and Release of Information

I, the undersigned authorize payment of medical benefits to ONE to ONE FemaleCare, PA, for any services furnished to me by the physician. I understand I am financially responsible for any amount not covered by my contract. I understand that if my balance goes unpaid more than 60 days a service fee will accrue each month. If it is necessary for my overdue account to go on to collections or a lawyer, I understand a surcharge and fees will be my responsibility. I also authorize you to release to my insurance company information concerning healthcare, advice, treatment or supplies provided to me. This information will be used for the purpose of evaluating and administering claims of benefits.

Signature____Date______________________________

Medicare Lifetime Signature on File

I, request that payment of authorized Medicare benefits be made on my behalf to ONE to ONE FemaleCare, PA, for any services furnished to me by the physician. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or benefits payable for related services.

Signature____Date______________________________