MY PHARMACY IS:
Name:_____
Location:_____
Phone #:_____

Institute for Female Pelvic Medicine
PATIENT INFORMATION RECORD

BLACK INK ONLY

Home Phone_____ Cell Phone_____

Date_____ Email _____

Patient Name(legal) _____

Address_____ City_____ State_____ Zip_____

Birth Date_____ SS#_____ Marital Status_____ Full Time Student_____

Occupation_____ Employer/School_____ Phone_____

Spouse Name_____ Employer_____ Phone_____

Spouse Birthdate _____ SS#_____

Race _____ Preferred Language _____ Ethnicity _____

Notify In Emergency_____ Phone_____ Relationship_____

Referred By_____

Financial Responsibility (if different than above)

Name_____ Birthdate _____ Phone _____ SS# _____

Address_____ City_____ State_____ Zip_____

Employer_____ Phone_____ Relationship to Patient_____

INSURANCE – PLEASE PRESENT YOUR INSURANCE CARD TO THE RECEPTIONIST

Primary Insurance Carrier_____ Effective Date_____

Insurance Address_____

ID#_____ Group#_____

Subscriber's Name_____ SS#_____ Birthdate _____

Secondary Insurance Carrier_____ Effective Date_____

Insurance Address_____

ID#_____ Group#_____

Subscriber's Name_____ SS#_____ Birthdate _____

INITIAL

_____ I consent to treatment necessary for the care of the above named patient.

_____ I authorize the release of all medical records to the referring or treating physicians and to my insurance company, if applicable.

_____ I allow fax transmittal of my medical records if necessary.

_____ I understand that payment of charges incurred is due at the time of service unless other definite financial arrangements have been made prior to treatment.

_____ If this account becomes past due, I agree to pay all reasonable collection costs. If legal action is required to collect this account, I agree to pay all attorney fees and court costs.

_____ I further authorize and request that insurance payments be made directly to Institute for Female Pelvic Medicine., should they elect to receive such payment.

_____ I have read and fully understand the above consent for treatment, financial responsibility, release of medical information, and insurance authorization.

SIGNATURE: _____ DATE _____