

PATIENT INFORMATION (Please Print Clearly)

Name _____ DOB _____ Marital Status S M W D Sep
Street Address _____ City, State, Zip _____
Home Phone _____ Work Phone _____ Cell# _____
SS# ____ - ____ - ____ Employer _____
Spouse's Name _____ DOB _____
Spouse's Employer _____ Spouse's Work Phone # _____
Emergency Contact _____ Phone # _____
Primary Care Physician _____ Phone # _____
If you are a new patient, please tell us who referred you to us _____

PRIMARY INSURANCE INFORMATION

Insurance Company _____ Effective Date: ____/____/____
Ins. Co. Address _____
Policy/Certificate# _____ Group# _____
Policy Holder Name _____ Relationship to Patient _____
Policy Holder's Social Security # ____ - ____ - ____ Date of Birth _____
Employer of Policy Holder _____

SECONDARY INSURANCE INFORMATION

Insurance Company _____ Effective Date: ____/____/____
Insurance Company _____ Effective Date: ____/____/____
Ins. Co. Address _____
Policy/Certificate# _____ Group# _____
Policy Holder Name _____ Relationship to Patient _____
Policy Holder's Social Security # ____ - ____ - ____ Date of Birth _____
Employer of Policy Holder _____

- You are responsible for providing us with accurate insurance information and updating the information as changes occur.
- Your insurance may be of a type that will not pay for specialist's services unless you obtain an authorization from your primary care physician before you see the specialist.
- You are responsible for copayments, insurance deductibles, and uncovered fees.
- In the event that your account becomes delinquent, you will be responsible for all costs resulting from our efforts to collect outstanding balances.
- You may receive bills from other providers for tests or services (lab, x-rays, specialists, etc.)
- I understand that a fee will be imposed for any missed appointment without a 24 hour advance notice of cancellation.
- I hereby authorize Bedford Women's Care Associates, P.A. to release billing and medical information regarding my care for purposes of : conducting normal healthcare operations, determining liability for payment, obtaining payment for services rendered, reviewing the quality of services provided, and establishing that services are medically necessary. Additionally, I understand that during the course of my treatment my medical information may be provided to or discussed with consultants, nurses, and other providers for the purpose of providing care.

Signed _____ Date _____

(Patient, parent of minor, or legal representative)

Print Name and Relationship to Patient _____

Updated: ____/____/____ Initials: ____/____/____ Updated: ____/____/____ Initials: ____/____/____