Bedford Women's Care Associates, PA

PATIENT INFORMATION (Please Print Clearly)

Name_______________________________________ D.O.B_________________Marital Status S M W D Sep

Gender Female Male Ethnicity Unknown Hispanic/Latino Non Hispanic/Latino Declined

Race American Indian/Alaska Native Asian Black/African American Nat Hawaiian/Pacific Islander
Other White Unknown Declined

Street Address___________________________________City/State/Zip________________________________

Home Phone_____________________Cell Phone_________________Work Phone/Ext__________________

Email Address________________________Pharmacy Name & Number_______________________________

Preferred BWCA/GYN Provider_____________________Primary Care Physician and #__________________

SS#____-____-____ Employer____

Spouse's Name____D.O.B.____________________

Spouse's Employer____________________________Spouse's Work Phone____________________________

Emergency Contact____Day Phone________________________

If you are a new patient, please tell us who referred you to us:____

PRIMARY INSURANCE INFORMATION

Insurance Company____Effective Date:____/____/____
Ins. Company Address____
Insurance ID#______________________________________Group#______________________________________
Policy Holder Name___________________________________Relationship to patient____________________
Policy Holders' Social Security #_____ - _____ - _____ Date of Birth_______________________________
Employer of Policy Holder____

SECONDARY INSURANCE INFORMATION

Insurance Company____Effective Date:____/____/____
Ins. Company Address____
Insurance ID#______________________________________Group#______________________________________
Policy Holder Name___________________________________Relationship to patient____________________
Policy Holders' 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 specialists' services unless you obtain an authorization from your primary care physician before you see the specialist.
- You are responsible for copayments, insurance deductibles, and other 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 test or services (lab, x-rays, specialist, ect.)
- ***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 Associate, PA* to release billing and medical information regarding my care for the 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:________Updated:___/___/____ Initials:__________