Peoria Women's Health

PATIENT INFORMATION

Patient Name _____**Maiden Name**_____

Address _____
Street **City** **State** **Zip Code**

Email _____

Home Phone ( )_____ **Cell** ( ) _____**Work #**_____

Date of Birth _____/_____/_____ **SS#**_____/_____/_____

REFERRING/FAMILY PHYSICIAN

Name_____**Phone**_____

SPOUSE/PARENT INFORMATION

Name_____**DOB**____/____/____ **SS#**____/____/_____

EMERGENCY CONTACT

Name_____**Relationship**_____**Phone**_____

INSURANCE INFORMATION

PRIMARY

Ins. Co._____**Group#**_____**Subscriber#**_____

Insured: _____**Self** _____**Spouse**_____**Other**_____(List Relationship)

Insured Name_____**Insured DOB**____/____/_____

SECONDARY

Ins. Co._____**Group#**_____**Subscriber#**_____

Insured Name_____**Insured DOB**____/____/____**Relationship**_____

I authorize payment of benefits, as determined by the company directly to Peoria Women's Health. I understand that I may still be responsible for any amounts not paid by my insurance company in the event that the charges made are applied to my deductible, copay, co-insurance or are not reasonable or customary.

SIGNATURE_____**DATE**_____

I authorize any insurance company, organization, employer, hospital, physician or pharmacist to release any information requested with regard to processing my claim. I certify that information is true and correct. I know it is a crime to fill out this form with facts I know are false or leave out facts I know are important.

SIGNATURE_____**DATE**_____