Women's Care of Mansfield

PATIENT INFORMATION
PLEASE PRINT

Patient Information

Name: _____________ Date of Birth: _______ Age: ______ Are you a new patient? □ Yes □ No
Address: ________________________________ City: __________________ State: ________ Zip Code: _______
Race:* __________ Ethnicity:* _________ Primary Language:*_________ ***Required by Healthcare/Meaningful Use Legislation**
Email address: ________________________ Preferred Pharmacy: _____________ Location: _______________
Cell Phone: _________________ Home Phone: _________________ Work Phone: ________________________

Patient is: Is the patient a student? □ Yes □ No
□ Single □ Married □ Separated □ Divorced □ Widowed If yes, □ Full-Time □ Part-time

Patient's Employer: _____________________________ Insurance through patient's employment? □ Yes □ No
If yes, Insurance Co. Name: ______________ Policy #____________ Group #___________ Plan Code ________
Is the patient on Medicare? □ Yes □ No Is the patient on Medicaid?
If yes, Medicare No. ____________________________ If yes, Medicaid No. _____________________
Primary Care Physician: _________________________ Address: _______________________________________

Husband/Partner Information

Name: ______________________ Date of Birth: _______ Social Security No. ________Relationship: ________
Address: _____________________________ City: _____________________ State: ________ Zip Code: _______
Employer: _________________________________ Insurance through spouse/partner? □ Yes □ No
If yes, Insurance Co. Name: ______________Policy #____________ Group #___________ Plan Code ________

Parent/Guardian Information

Father:
Name: ___________________ Date of Birth: ________ Social Security No. ________ Relationship: __________
Address: _____________________________ City: _____________________ State: ________ Zip Code: _______
Mother:
Name: ___________________ Date of Birth: ________ Social Security No. ________ Relationship: __________
Address: _____________________________ City: _____________________ State: ________ Zip Code: _______

Please sign below so that our office may complete your insurance claims. THANK YOU.
I authorize Women's Care Inc. to release all information necessary to process an insurance claim.
I authorize payment of medical and/or surgical benefits to Women's Care Inc. (including Medicare, other government sponsored programs, private insurance and any other health insurance plan). I understand that I am financially responsible for medical charges, whether or not paid by my insurance.
Women's Care Inc. is not responsible for any claimed errors in payment not exceeding the actual charge.
The resolution of any such matter is solely between the insurer and the patient or subscriber.
This authorization will remain in effect until revoked in writing. A photocopy of this authorization is to be considered as valid as an original.

Patient Signature: ____ Date: ______________________________