The Women's Clinic of Vancouver, PS

Doctor: _____

PATIENT INFORMATION

Name: _____ **Patient ID #:** _____ **Sex:** [ ]M [ ]F

Address: _____ **Date of Birth:** _____

_____ **Social Security #:** _____

City,State, Zip: , _____ **Marital Status:** [ ]Married [ ]Single [ ]Divorced

Phone: _____ [ ]Home [ ]Work [ ]Other **Referring Physican:** _____

Phone: _____ [ ]Home [ ]Work [ ]Other **Primary Physician:** _____

PATIENT'S EMPLOYMENT INFORMATION

[ ]Employed [ ]Retired [ ]Other

Phone: _____

Employer: _____

EMERGENCY CONTACTS

Name	Relationship	Phone

GUARANTOR INFORMATION

( ) Same As Patient ( ) Spouse ( ) Parent

Name: _____ **Employer:** _____

Phone: _____

Address: _____ **Phone 2:** _____

SSN: _____

City,State, & Zip : _____ **Date of Birth:** _____

PRIMARY INSURANCE INFORMATION

[ ]Same as Patient [ ]Same as Guarantor [ ]Other

Insured Party Name: _____

Insured Phone: _____

Insurance Company: _____

Relationship to Patient: _____

Social Security #: _____

Insured ID: _____

Policy Group: _____

Insured's Date of Birth: _____

SECONDARY INSURANCE INFORMATION

[ ]Same as Patient [ ]Same as Guarantor [ ]Other

Insured Party: _____

Insured Phone: _____

Insurance Company: _____

Relationship to Patient: _____

Social Security #: _____

Insured ID: _____

Policy Group: _____

Date of Birth: _____

I HEREBY AUTHORIZE THE WOMEN'S CLINIC OF VANCOUVER,PS, TO FURNISH THE INSURANCE CARRIER WITH ANY INFORMATION CONCERNING MY PRESENT ILLNESS OR INJURY. IF MY INSURANCE COMPANY REQUIRES A REFERRAL FOR THIS OR FUTURE VISITS, AND IS NOT OBTAINED, I WILL BE RESPONSIBLE FOR ANY CHARGES INCURED. I GUARANTEE PAYMENT FOR ALL CHARGES WHETHER OR NOT PAID FOR BY INSURANCE, AND UNDERSTAND THAT I WILL BE ASSESSED A FINANCE CHARGE OF 1.5% PER MONTH OR 18% PER YEAR ON BALANCES NOT PAID IN FULL WITHIN 90 DAYS.

_____ _____

PATIENT/GUARDIAN SIGNATURE DATE

_____ _____

PATIENT/GUARDIAN SIGNATURE DATE

I ALSO ASSIGN PAYMENTS FROM INSURANCE, INCLUDING MAJOR MEDICAL BENEFITS, TO THE WOMEN'S CLINIC OF VANCOUVER,PS.

_____ _____

PATIENT / GUARDIAN SIGNATURE DATE

05/15/2008

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