Patient information

(Picture ID and Insurance Card(s) required)

Referred By: _____

Patient's Legal Name _____ Birth Date: _____

Social Security #: _____ Driver's License #: _____

Street Address: _____ Marital Status: M S D W

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell: _____

Occupation: _____ Employer: _____

Employer Address: _____

Emergency Contact: _____ Relationship: _____ Phone: _____

Primary Insurance information

Insured, Responsible Party: _____ Relationship: _____
(If insured under someone other than yourself, we need their name and Date of Birth)

Birth Date: _____ Social Security #: _____

Insured's Employer: _____ City: _____ Work Phone: _____

Insurance Carrier: _____

Policy #: _____ Group #: _____ Effective Date: _____

Secondary Insurance Information

Insured, Responsible Party: _____ Relationship: _____

Birth Date: _____ Social Security #: _____

Insured's Employer: _____ City: _____ Work Phone: _____

Insurance Carrier: _____

Policy #: _____ Group #: _____ Effective Date: _____

ASSIGNMENT OF BENEFITS/FINANCIAL AGREEMENT/AUTHORIZATION TO RELEASE MEDICAL INFORMATION

I hereby give authorization for payment of insurance benefits to be made directly to Dr. Michelle A. Marine and/or Dr. Stuart J. Fischbein for services rendered. I understand that I am financially responsible for all charges whether or not they are covered by insurance. In the event of default I agree to pay for any courtroom and reasonable attorney fees. I hereby authorize this healthcare provider to release all information necessary to secure the payment of benefits. I hereby agree that a photocopy of this agreement shell be as valid as the original.

Signature: _____ Date: _____

The Woman's Place

for Health & Midwifery Care

Name	Date of birth	
Address	Phone	

Date of last menstrual period_____Any problems with your periods?_____
Last pap smear_____Current birth control method_____
Have you or anyone in your immediate family had any changes in your health since your last visit? If so, what?

_____

_____

Do you have any allergies?_____Current medications?_____
Regular exercise?_____Vitamins or calcium supplements?_____
Do you smoke?_____ (per day) Use alcohol_____(oz/week) Drugs_____

WHY ARE YOU HERE TODAY?

_____

_____

_____

CLIENT HISTORY

DATE: