WOMEN'S HEALTH CARE SPECIALIST, P.C.

505 Hazen Street Suite 204, Paw Paw, MI 49079 * 5555 Gull Road, Kalamazoo, MI 49048

PATIENT INFORMATION

Last Name	First Name	Middle Initial	Date of Birth / /	Age

Mailing Address	City	State	Zip Code

Do we have permission to leave a message? **YES NO**	Home Phone	Work Phone	Social Security	Maiden Name

Emergency Name & Number	Marital Status **S M W D**	Drivers License Number

Employer	Employer Address	City	State	Zip Code	Phone

Primary Insurance	Policy Number	Subscriber Number	Effective Date
Secondary Insurance	Policy Number	Subscriber Number	Effective Date

Name you wish to be called by the staff?	Primary Care Physician	Parent/Guardian Name(if under 18)

How did you hear of our office?	If you would like to receive Practice info. & updates via email, please enter your E-Mail Address

SUBSCRIBER INFORMATION

Last Name	First Name	Middle	Date of Birth / /	Age

Mailing Address	City	State	Zip Code

Day Phone	Evening Phone	Social Security	Drivers License Number

Employer	Employer Address	City	State	Zip Code	Phone

I hereby authorize my insurance benefits to be paid directly to Women's Health Care Specialist, P.C., realizing I am responsible to pay any non-covered services. I will be responsible for any additional rebilling fees, collection agency fees, court cost and/or attorney fees which may be charged as a result of efforts to collect a past due balance. I understand that the provider's charge may exceed the insurance payment, and if greater than such payment, I will be responsible for that additional amount. If I request that insurance claims be resubmitted due to lack of correct information, I will be responsible for a rebilling fee. I hereby authorize the release of pertinent medical information which may include mental, physical, substance abuse, HIV related, AIDS or AIDS related information to the extent by law to insurance carriers, referral physicians, and/or facilities.

For any questions regarding charges/fees for services provided by Women's Health Care Specialist, P.C., please inquire prior to services being rendered.

I have been given the opportunity to receive a copy of Women's Health Care Specialist HIPPA form and I have verified the above information to be correct and current to the best of my knowledge.

Patient and/or Guardian Signature____**Date**____________

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