

Women's Health Care

2700 SE Stratus Ave., Ste 405
McMinnville, OR 97128

Obstetrics Gynecology

Phone: 503/435-2020
Fax: 503/435-1838

| PATIENT INFORMATION | | | |
|-------------------------|------|------------------------------------------------------------------------------------------------------------------------------------------|-------------------|
| PATIENT NAME: | | <input type="checkbox"/> SINGLE <input type="checkbox"/> MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED | |
| ADDRESS: | | P.O. BOX: | |
| CITY: | | STATE/ZIP: | |
| HOME PHONE: | | WORK PHONE: | OTHER PHONE: |
| BIRTHDATE: | AGE: | SEX: | SOC. SEC. NUMBER: |
| EMPLOYER: | | OCCUPATION: | |
| ADDRESS: | | CITY: | STATE/ZIP: |
| PRIMARY CARE PHYSICIAN: | | REFERRED BY: <input type="checkbox"/> PCP <input type="checkbox"/> FRIEND <input type="checkbox"/> RELATIVE <input type="checkbox"/> ADS | |

| PERSON RESPONSIBLE FOR PAYMENT | | | |
|--------------------------------|------|-----------------------------------------------------------------------------------------------|-------------------|
| NAME: | | <input type="checkbox"/> SELF <input type="checkbox"/> SPOUSE <input type="checkbox"/> PARENT | |
| ADDRESS: | | P.O. BOX: | |
| CITY: | | STATE/ZIP: | |
| HOME PHONE: | | WORK PHONE: | |
| BIRTHDATE: | AGE: | SEX: | SOC. SEC. NUMBER: |
| EMPLOYER: | | OCCUPATION: | |
| ADDRESS: | | CITY: | STATE/ZIP: |

| INSURANCE | | |
|----------------------|---------------|--------------------------|
| PRIMARY INS. NAME: | POLICY# / ID# | GROUP# |
| SUBSCRIBER NAME: | BIRTHDATE: | RELATIONSHIP TO PATIENT: |
| EMPLOYER: | | |
| SECONDARY INS. NAME: | POLICY# / ID# | GROUP# |
| SUBSCRIBER NAME: | BIRTHDATE: | RELATIONSHIP TO PATIENT: |
| EMPLOYER: | | |

| IN CASE OF EMERGENCY | | |
|------------------------------------------------------------------------------------------|---------------|------------|
| NAME OF FRIEND OR RELATIVE NOT LIVING WITH YOU WHO COULD REACH YOU IN CASE OF EMERGENCY: | | |
| NAME: | RELATIONSHIP: | TELEPHONE: |

| AUTHORIZATION TO RELEASE INFORMATION * ASSIGNMENT OF INSURANCE BENEFITS * AGREEMENT / CONTRACT | |
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| I HEREBY AUTHORIZE WOMEN'S HEALTH CARE EMPLOYEES TO RELEASE TO MY INSURANCE COMPANY ANY INFORMATION ACQUIRED IN THE COURSE OF MY EXAMINATION OR TREATMENT (IF PATIENT IS A MINOR, PARENT OR GUARDIAN MUST SIGN) | |
| I HEREBY AGREE TO FULL RESPONSIBILITY FOR ALL EXPENSES INCURRED BY ME OR ON BEHALF OF THE ABOVE NAMED PATIENT AND HEREBY ASSIGN TO WOMEN'S HEALTH CARE ANY AND ALL INSURANCE BENEFITS DUE ME TO FULL EXTENT OF MY FINANCIAL OBLIGATION TO THE TREATING PHYSICIAN OR PROVIDER. | |
| I UNDERSTAND MY INSURANCE COVERAGE IS A RELATIONSHIP BETWEEN MYSELF AND MY INSURANCE COMPANY. I AGREE TO ACCEPT FINANCIAL RESPONSIBILITY FOR PAYMENT FOR CHARGES INCURRED. I UNDERSTAND THAT A REBILLING FEE COMPLYING WITH OREGON STATE LAW WILL BE APPLIED TO ANY OVERDUE BALANCE AND IN THE EVENT OF NON-PAYMENT, I WILL BEAR THE COST OF COLLECTION AND/OR COURT COSTS AND REASONABLE LEGAL FEES SHOULD THIS BE REQUIRED. | |
| SIGNED: | DATE: |