RHETT WOMEN'S CENTER

Patient Information

Full Name _____Preferred Name_____

Date of Birth_____ Social Security Number_____

Address_____

City_____ State_____ Zip _____ Email Address_____

Home Phone # _____Work Phone #_____ Cell Phone #_____

May we leave a message on your home or cell phone? ☐YES ☐NO

Emergency Contact Name: _____ Relationship: _____Phone # _____

How Did You Hear About Us? _____

Primary Insurance

Policy # _____ Group #_____

Policy Holder:_____Date of Birth_____Relationship to Patient _____

Insurance Co. Name_____Insurance Co. Phone # _____

Insurance Co. Address _____

Secondary Insurance

Policy # _____ Group #_____

Policy Holder:_____Date of Birth_____Relationship to Patient _____

Insurance Co. Name_____Insurance Co. Phone # _____

Insurance Co. Address _____

I understand that payment is due at the time service is rendered.

I hereby authorize the release of any medical information to my insurance company through which I claim benefits. I hereby assign all benefits that I am entitled, including Medicare, private insurance, group policy benefits, or other health plans to Rhett Women's Center.

I understand that I am financially responsible to Rhett's Women's Center for all charges not covered, approved or considered necessary by my insurance company. I will pay at the time of service or have an agreeable payment arrangement set up with the business office.

_____ Date _____

Patient or Responsible Party Signature

_____ Date _____

Patient or Responsible Party Signature

_____ Date _____

Patient or Responsible Party Signature

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