Patient Information

Last Name_____First name_____MI____Maiden_____

Address_____City_____State_____Zip_____

Home ( )_____Cell ( )_____Work/Ext ( )_____/_____

Email Address_____@_____Marital Status_____

Date of Birth_____/_____/_____ Age _____SSN_____-_____-_____Ethnicity_____

Employer_____Occupation_____

Doctor to be seen: DR JENKINS / DR MOORMA **Referring Physician:**_____

How did you hear about us?	Insurance Co.	Current Patient	Internet	Friend

Emergency Information

Name_____Relationship_____

Address_____ Contact ( )_____

Primary Insurance

Company_____Contact ( )_____

Name of Insured (if not patient)_____Relationship_____

Subscriber ID_____Group_____

Date of Birth_____/_____/_____ SSN_____-_____-_____Employer_____

Secondary Insurance

Company_____Contact ( )_____

Name of Insured (if not patient)_____Relationship_____

Subscriber ID_____Group_____

Date of Birth_____/_____/_____ SSN_____-_____-_____Employer_____

All professional services are charged to the patient. The necessary form will be completed to help expedite insurance carrier payments. However, the patient is responsible for all fees, regardless of insurance coverage. It is also customary to pay for services when rendered unless other arrangements have been made in advance with our billing manager. I hereby authorize Crosswoods Women's Health to furnish information to insurance carriers concerning my illness and treatments, and I hereby assign to the physician all payments for medical and surgical services rendered to myself. I understand that I am responsible for any amount not covered by insurance. I agree that you may contact me by telephone (at any phone number associated with my account, including wireless telephone numbers which could result in charges to me) in order to provide services to me and/or to collect any amounts that I may owe. Methods of contact may include; direct calling, prerecorded/artificial voice messages, automated dialing devices, texting and/or email as applicable.

I/we have read this disclosure and agree that the provider/credit agency may contact me/us as described above.

Date_____/_____/_____Signature_____