PATIENT INFORMATION FORM

METRO PARTNERS IN WOMEN'S HEALTH

Today's Date: _____

Patient Name: _____ **Social Security #:** _____

Address: _____

City: _____ **State:** _____ **Zip:** _____

Phone: Home: _____ Office: _____ Cell: _____

Date of Birth: _____ **Marital Status:** _____

Email Address: _____

Race: _____ **Ethnicity:** _____ **Language:** _____

Employer: _____ **Occupation** _____

Primary Care Physician Name: _____

Messages regarding my results/treatment may be left on my cell or home phone: O Yes O No
Messages regarding my results/treatment may be left on my work voice mail: O Yes O No
Messages regarding my results/treatment may be left with my spouse/parent: O Yes O No

Pharmacy Name: _____ **Pharmacy #:** _____

Pharmacy Address: _____

Emergency Contact: _____ **Relationship:** _____

Phone: Home: _____ Office: _____ Cell: _____

INSURANCE INFORMATION

Insurance: _____ **Employer:** _____

Subscriber Name: _____ **Subscriber Date of Birth:** _____

Subscriber Address: _____

City _____ **State:** _____ **Zip:** _____

I have provided MPIWH with a copy of my Advance Directive: O Yes O No
If No, I have been offered information regarding Advance Directives: O Yes O No

I hereby authorize and provide consent to Metro Partners in Women's Health Providers to furnish the requested diagnostic services and/or treatment and bill for services rendered.

I authorize payment of medical benefits to Metro Partners in Women's Health for services provided. I understand that if my insurance company does not reimburse services, I will be responsible.

Patient/Authorized Person Signature: _____ **Date:** _____

****Authorization valid for 1 year from date of signature****