Women's Health Inc. **Dr. Alan Binette**

Patient Information

Patient Name:_____ Preferred Name:_____ DOB:_____ Age:_____
(Last) (First) (Middle)

Home Phone: (_____)_____-_____ Work Phone: (_____)_____-_____ Cell Phone: (_____)_____-_____

Preferred Phone Number: Home Work Cell Ok to leave voicemail: Yes No

Physical Address:_____
(Street) (City) (State) (Zip code)

Mailing Address:_____
(Street) (City) (State) (Zip code)

Patient Employer:_____ Position:_____ Social Security #:_____

Spouse/Responsible Party Information

Spouse/Parent Name:_____ Date of Birth:_____

Social Security #:_____ Phone Number: (_____)_____-_____

Employer:_____ Position:_____ Work Number: (_____)_____-_____

Emergency Contact:_____ Relationship:_____ Phone: (_____)_____-_____

Insurance Information

Primary Care Physician:_____ Referred By:_____

Primary Insurance:_____ ID/Policy Number:_____ Group Number:_____

Subscriber Name: _____ Subscriber Date of Birth:_____

Secondary Insurance:_____ ID/Policy Number:_____ Group Number:_____

Subscriber Name: _____ Subscriber Date of Birth:_____

******IF PHARMACY/PRESCRIPTION COVERAGE IS DIFFERENT FROM ABOVE, PLEASE PROVIDE BELOW. WE ARE UNABLE TO FACILITATE ANY REQUESTS CONCERNING MEDICATIONS OR AUTHORIZATIONS FOR MEDICATIONS WITHOUT THIS INFORMATION.******

Insurance Carrier:_____ ID/Policy Number:_____ Group Number:_____

Subscriber Name: _____ Subscriber Date of Birth:_____

COPAYS ARE DUE AT TIME OF SERVICE

I AUTHORIZE THE RELEASE OF ANY MEDICAL OR OTHER INFORMATION NECESSARY TO PROCESS THIS CLAIM, AND THAT PAYMENT OF THE BENEFITS BE MADE DIRECTLY TO MY PROVIDER OF SERVICE. I UNDERSTAND I AM RESPONSIBLE FOR ALL CHARGES INCURRED SHOULD THE INSURANCE NOT PAY FOR SERVICES RENDERED. I UNDERSTAND IT IS MY RESPONSIBILITY TO SUPPLY CURRENT AND ACCURATE INSURANCE INFORMATION. WOMEN'S HEALTH INC. WILL NOT BE RESPONSIBLE FOR DENIAL OF CLAIMS WHEN INCORRECT INFORMATION IS SUPPLIED.

Patient/Representative Signature:_____ Date:_____