sacramento women's health
an ob/gyn partnership

Patient Information

Patient's Name _____ Date of Birth _____

Address _____ City _____ State _____ Zip _____

Home Phone _____ Cell _____ Marital Status S M W Div Sep

Email _____ @ _____ Work Phone _____

Occupation _____ Social Security # _____

Employer _____

Partner's Name _____ Date of Birth _____ SS No _____

Race: ___Caucasian/white ___African American ___Chinese ___Filipino ___ English___ Spanish ___ Japanese
___ Korean ___ Vietnamese ___ Other Pacific Islander ___ Mexican ___ Other Spanish ___ Other _____
Interpreter needed ___yes ___ no

Primary Care Physician: _____ Medical Group _____

Person to Notify in Case of Emergency _____

Phone _____ Relationship _____

Pharmacy Preference _____

Address _____ Phone Number _____

Authorization for Assignment of Benefits and Information Release

I, the undersigned, authorize payment of medical benefits to Sacramento Women's Health for any services furnished to me by the physicians. I understand I am financially responsible for any services not covered by my insurance. I further agree to pay reasonable attorney fees and court costs in the event that legal action becomes necessary to enforce this contract. I also authorize you to release my insurance company information concerning health care, advice, treatment or supplies provided to me. This information will be used for the purpose of evaluating and administering claims of benefits.

Date _____ Signed _____

Insurance Company _____ ID# _____

Insurance subscriber: ___Self ___Partner___Parent ___ other ___

Subscriber name: _____ Subscriber Date of Birth _____

Secondary Insurance _____ ID# _____

Insurance subscriber: ___Self ___Partner ___Parent ___ other ___

Subscriber name: _____ Subscriber Date of Birth _____