SIERRA WOMEN'S HEALTH

Please use black ink.

DATE____

PATIENT NAME____AGE_____________________
(First) (Middle) (Last)

DATE OF BIRTH________________________SOCIAL SECURITY #___________________________MARITAL STATUS____________

MAILING ADDRESS____CITY________________________STATE_____ZIP____________

HOME TELEPHONE (_____)____________________________CELLULAR TELEPHONE(_____)________________________________

EMPLOYER____REFERRED BY____

EMPLOYER ADDRESS_____________________________________CITY_______________________STATE_____ZIP_____________

POSITION OCCUPIED______________________________________WORK TELEPHONE_____________________EXT_____________

❖❖

SPOUSE OR PARENT____DATE OF BIRTH________________________________

MAILING ADDRESS____HOME TELEPHONE (_____)______________________

EMPLOYER____SOCIAL SECURITY #_______________________________________

❖❖

EMERGENCY CONTACT NOT LIVING WITH YOU____________________________________RELATIONSHIP____________________

ADDRESS____TELEPHONE(_____)____________________

❖❖

YOUR CO-PAYMENT MUST BE PAID AT THE TIME OF SERVICE. PLEASE INDICATE METHOD OF PAYMENT.

________CHECK/CASH ________MASTERCARD/VISA

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YOU MUST BRING YOUR INSURANCE CARD WITH YOU AT THE TIME OF YOUR VISIT.

YOUR INSURANCE COMPANY____

INSURANCE ADDRESS____

NAME OF INSURED__________________________________GROUP #___________________________ID #________________________

I hereby authorize Sierra Women's Health to furnish to my insurance company all medical information which my insurance company may request concerning my medical condition.

____
(Patient Signature)

I hereby authorize payment of medical benefits to Sierra Women's Health for medical or surgical services rendered to me by Sierra Women's Health. I understand that I am financially responsible for charges not covered by this authorization.

____
(Insured Signature)

Sierra Women’s Health has provided me with a copy of their Notice of Privacy Practices _________Please Initial

Do you have an Advanced Directive? ☐ Yes ☐ No If so, please allow our office to keep a copy in your medical record.

IMPORTANT - PLEASE READ CAREFULLY: MOST INSURANCE COMPANIES REQUIRE THAT THE INSURED USE A CONTRACT FACILITY (HOSPITAL, LABORATORY, RADIOLOGY DEPARTMENT, ETC.) IN ORDER TO OBTAIN MAXIMUM REIMBURSEMENT. PRIOR TO YOUR VISIT, YOU SHOULD CONTACT THE PERSON HANDLING YOUR INSURANCE TO FIND OUT IF THIS APPLIES IN YOUR CASE. **IT IS YOUR RESPONSIBILITY TO ADVISE US IF A CONTRACT FACILITY IS TO BE USED.**