ONE to ONE FemaleCare, PA

PATIENT DEMOGRAPHICS (PLEASE PRINT)

Name _____
(first) (middle) (last)
Date of Birth _____ Marital Status _____ Social Security # _____
Race _____ Ethnicity: Hispanic/Latino or NonHispanic/Latino Primary Language _____
(Circle One)
Address _____ City _____ State _____ Zip _____
Home # _____ Work # _____ Cell # _____
Email _____ Pharmacy Name/Phone _____

REFERRING INFORMATION

Primary Care Physician _____
(name & address, if possible)
Referring Physician (if different) _____
How did you find out about the practice? Friend/Family _____
(name & address)
Mailing _____ Newspaper _____ Yellow Pages _____ Internet _____

INSURANCE INFORMATION

Patient Occupation _____ Fulltime _____ Parttime _____
Employer _____
(name & address)
Name of Spouse/Parent _____ Cell Phone _____
(name & address)
Home Address _____ Home Phone _____
(if different from patient)
Employer _____ Work Phone _____

Primary Insurance Company _____ Policy Holder _____
SS# _____ DOB _____ Relation to Patient _____
ID/Policy# _____ Group# _____
Secondary Insurance Company _____ Policy Holder _____
SS# _____ DOB _____ Relation to Patient _____
ID/Policy# _____ Group# _____

CONTACT INFORMATION (In Case of Emergency)

Contact _____ Home Phone _____
(name & relationship)
Cell Phone _____ Work Phone _____

Private Insurance Authorization for Assignment of Benefits and Release of Information
I, the undersigned authorize payment of medical benefits to ONE to ONE FemaleCare, PA, for any services furnished to me by the physician. I understand I am financially responsible for any amount not covered by my contract. I understand that if my balance goes unpaid more than 30 days a service fee will accrue each month of 1.5%. If it is necessary for my overdue account to go on to collections or a lawyer, I understand an 18% fee will be my responsibility. I also authorize you to release to my insurance company information concerning healthcare, advice, treatment or supplies provided to me. This information will be used for the purpose of evaluating and administering claims of benefits.

Signature _____ Date _____

Medicare Lifetime Signature on File
I, request that payment of authorized Medicare benefits be made on my behalf to ONE to ONE FemaleCare, PA, for any services furnished to me by the physician. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or benefits payable for related services.

Signature _____ Date _____