



**PATIENT INFORMATION (PLEASE PRINT)**

Name \_\_\_\_\_ Maiden Name \_\_\_\_\_ Social Security # \_\_\_\_\_  
(Last) (First) (MI)  
Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_  
Phone ( ) \_\_\_\_\_ Cell Phone ( ) \_\_\_\_\_ Age \_\_\_\_\_ Date of Birth \_\_\_\_\_  
Marital Status: S M W D Primary Care or Referring Physician \_\_\_\_\_ Phone \_\_\_\_\_  
Patient Employed by \_\_\_\_\_ Occupation \_\_\_\_\_  
Business Address \_\_\_\_\_ Business Phone \_\_\_\_\_  
Emergency Contact \_\_\_\_\_ Relationship \_\_\_\_\_ Phone \_\_\_\_\_  
How did you hear about our clinic? Relative Friend Yellow Pages Newspaper Internet Radio Other \_\_\_\_\_

**PRIMARY INSURANCE INFORMATION**

Insured's Name (This is often not the same as Patient) \_\_\_\_\_  
(Last Name) (First Name) (MI)  
Relationship to Patient \_\_\_\_\_ Date of Birth \_\_\_\_\_ Soc. Sec. # \_\_\_\_\_  
Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_  
Phone \_\_\_\_\_ Insurance Name \_\_\_\_\_ Phone \_\_\_\_\_  
Insurance Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_  
ID # \_\_\_\_\_ Group # \_\_\_\_\_ Effective Date \_\_\_\_\_  
Employer Name \_\_\_\_\_ Phone \_\_\_\_\_  
Employer Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_

**SECONDARY INSURANCE INFORMATION**

Is patient covered by additional insurance? \_\_\_\_\_ if yes, please fill in below:  
Insured's Name (This is often not the same as Patient) \_\_\_\_\_ Date of Birth \_\_\_\_\_  
Relationship to patient \_\_\_\_\_ Soc. Sec. # \_\_\_\_\_ Phone \_\_\_\_\_  
Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_  
Insurance Name \_\_\_\_\_ Address \_\_\_\_\_  
Phone \_\_\_\_\_ ID# \_\_\_\_\_ Group # \_\_\_\_\_  
Employer Name \_\_\_\_\_ Phone \_\_\_\_\_  
Employer Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_

**ASSIGNMENT AND RELEASE:** I hereby authorize Beaver Dam Women's Health, Ltd. to release to my insurance carrier or its representatives any information including the diagnosis and records related to any treatment or examination rendered to me during the period of such Medical or Surgical care. I also authorize and request your company to pay directly to Beaver Dam Women's Health, Ltd. the amount due for basic medical, major medical and/or surgical treatment. I understand that I am financially responsible for all charges whether or not paid by insurance.

\_\_\_\_\_  
Signature of Insured/Guardian Date

**MEDICARE AUTHORIZATION:** I request that payment of authorized Medicare benefit be made on my behalf to Beaver Dam Women's Health, Ltd. 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 the benefits payable for related services. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If "other health insurance" is indicated in item 9 of the HCFA-1500 form, or elsewhere on other approved claim forms or electronically submitted claims, my signature authorized releasing of the information to the insurer or agency shown. In Medicare assigned cases, the provider agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance and non-covered services. Coinsurance and the deductible are based upon the charge determination of the Medicare Carrier.

\_\_\_\_\_  
Beneficiary Signature Date