

# Covenant Healthcare for Women, PLLC

Today's Date: \_\_\_\_\_

PCP: \_\_\_\_\_

## PERSONAL INFORMATION:

NAME: \_\_\_\_\_  
FIRST MIDDLE LAST

STREET ADDRESS CITY STATE/ZIP

(\_\_\_\_\_) \_\_\_\_\_  
HOME TELEPHONE

(\_\_\_\_\_) \_\_\_\_\_  
CELL PHONE

DATE OF BIRTH

SOCIAL SECURITY NUMBER

EMPLOYER'S NAME

(\_\_\_\_\_) \_\_\_\_\_  
WORK NUMBER

SPOUSE'S NAME

SPOUSE'S DATE OF BIRTH

SPOUSE'S EMPLOYER

(\_\_\_\_\_) \_\_\_\_\_  
SPOUSE'S WORK NUMBER

Race: \_\_\_\_\_

Where do you prefer to receive calls? \_\_\_\_\_ Home \_\_\_\_\_ Work \_\_\_\_\_ Mobile

May we leave information on your answering machine or voice mail? \_\_\_\_\_ Yes \_\_\_\_\_ No

### In the event of an emergency please contact:

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Pharmacy Information: Name of your pharmacy: \_\_\_\_\_

City: \_\_\_\_\_ Phone Number: \_\_\_\_\_

## BILLING INFORMATION (Who will pay for services not covered by insurance?)

Name insurance is under \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

Address \_\_\_\_\_

Date of Birth \_\_\_\_\_ Social Security # \_\_\_\_\_

Work Number \_\_\_\_\_ Home Number \_\_\_\_\_

## INSURANCE INFORMATION (You MUST provide the card for us to copy)

### Do you have other insurance that is not listed on this form? Yes or No

PRIMARY INS CO \_\_\_\_\_

SECONDARY INS CO \_\_\_\_\_

ID # \_\_\_\_\_ Group # \_\_\_\_\_

ID # \_\_\_\_\_ Group # \_\_\_\_\_

Insured's Name \_\_\_\_\_

Insured's Name \_\_\_\_\_

Insured's DOB \_\_\_\_\_

Insured's DOB \_\_\_\_\_

Relationship to Patient SELF SPOUSE CHILD

Relationship to Patient: SELF SPOUSE CHILD

Employer \_\_\_\_\_

Employer \_\_\_\_\_

Insured's Social Sec # \_\_\_\_\_

Insured's Social Sec # \_\_\_\_\_

*I hereby authorize you to release any information, including the diagnosis and record of any treatment or examination rendered to me or my child during the period of such care to third party payers and/or other health practitioners. I authorize and request my insurance company to pay benefits otherwise payable to me directly to Covenant Healthcare for Women, PLLC. I understand that my insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on behalf of myself or my dependent.*

\_\_\_\_\_  
Patient's Signature (Parent's signature if under 18)

\_\_\_\_\_  
Date