ESTRELLA WOMEN'S HEALTH CENTER
Patient Information

Name: _____ Social Security Number: _____ Birthdate: _____

Address: _____ City, State, Zip: _____

Primary Phone: _____ Secondary Phone: _____ Marital Status: S M D W

E-Mail Address: _____ Race: _____ Employer: _____ Occupation: _____

Name and Phone # of Family Doctor: _____

Who may we thank for referring you to our office? _____

Emergency Contact: _____ Relationship: _____ Phone: _____

Spouse (if married) or Parent (if minor)

Name: _____ Social Security Number: _____ Birthdate: _____

Address: _____ City, State, Zip: _____

Phone: _____ Relationship: _____ Employer: _____

Insurance Information

Primary Insurance: _____

ID#: _____ Group #: _____

Policy Holder Name: _____

Relationship to Patient: _____

Policy Holder DOB and Sex: _____

Secondary Insurance: _____

ID#: _____ Group #: _____

Policy Holder Name: _____

Relationship to Patient: _____

Policy Holder DOB and Sex: _____

Do you currently have an Advanced Directive regarding your medical wishes? _____

Authorization, Assignment & Consent to Treat

The patient or authorized person agrees that the above information is correct and allows for the medical treatment as specified by physician or associate provider.

I hereby authorize Estrella Women's Health Center to release any information requested, including medical information, to any insurance company, employer, third party payer, or third party administrator for purposes of processing my claims. I hereby assign Estrella Women's Health Center ALL payments for medical services rendered to myself or dependents. As the responsible party, I agree that I am financially responsible for ANY unpaid amounts, and agree to pay service charges at the current rate, collection charges, bad check charges, and court costs including any reasonable attorney fees.

If required, I understand that I am responsible for obtaining an insurance referral to be seen in this office. I understand that I am responsible for any charges incurred due to denied benefits if a proper referral is not obtained.

Patient Signature: _____ Date: _____

Responsible Party Signature: _____ Date: _____