1. Patient's Full Name_____ DOB _____
Last, First, Middle

2. Home Address: _____
Street or Route City State Zip

3. Home Phone (____) _____Cell Phone (___) _____Email: _____

4. Race: (Please Circle) American Indian, Asian, African American, Native Hawaiian or Pacific Islander, Caucasian

5. Ethnicity: (Please Circle) Non-Hispanic, Hispanic

6. Patient's Social Security # _____

7. Employer _____ Address: _____Phone:_____

8. Primary Care Physician _____ Phone: _____

9. Emergency Contact _____Phone: _____

10. Relationship to Emergency Contact (Please Circle) Spouse Mother Father Child Other

11. Address: _____
Street or Route City State Zip

12. Marital Status_____ If Married, Name of Spouse_____
Last, First Middle

INSURANCE INFORMATION Please bring your insurance card with you to the front desk when you have completed this form.

Financial Responsibility (Please Circle) Self Other

PRIMARY INSURANCE COVERAGE

13. Name of Insurance Co. _____ Address _____

14. Subscriber's Name _____ Sex: M F
Last, First, Middle

15. Subscriber's Date of Birth _____ 16. Subscriber's Social Security # _____

17. Patient's Relationship to Subscriber (Please Circle) Self Spouse Child Other

18. Subscriber's Address: _____

19. Subscriber's ID # _____ 20. Group # _____

SECONDARY INSURANCE COVERAGE

21. Name of Insurance Co. _____ Address _____

22. Subscriber's Name _____ Sex: M F
Last, First, Middle

23. Subscriber's Date of Birth _____24. Subscriber's Social Security # _____

25. Patient's Relationship to Subscriber (Please Circle) Self Spouse Child Other

26. Subscriber's Address: _____

27. Subscriber's ID # _____ 28. Group # _____

PATIENT RIGHTS AND NOTICE OF PRIVACY PRACTICES: I understand and acknowledge that I have been offered **UHCW Notice of Privacy Practices** information regarding my rights and responsibilities as a patient and via following link to U.S. Department of Health and Human Services on Practice Policies Page of **UHCW** website: http://www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html

_____ **Initials**

I hereby authorize my insurance benefits to be paid to UpToDate Healthcare for Women (UHCW), realizing I am responsible to pay non covered services and I hereby authorize the release of pertinent medical information to insurance carriers. I also hereby authorize UHCW to release my medical information to any licensed physician, healthcare provider or medical facility to which the patient may be referred, admitted, or transferred for further medical care. I understand that I may revoke this authorization by written notice at any time except to the extent that action has been taken. To my knowledge, the above information is true and correct.

Signature _____ Please check one: ☐ Patient ☐ Authorized Representative

Date _____ ☐ Parent or Guardian of Minor