ADRIATICA
Women's Health
OB/GYN

Patient Demographics

Please indicate below the preferred # to contact you, including location (i.e. Hm, Wk, Cell or other)

Ph#1_____Ph#2 _____Ph#3_____

Name _____ DOB _____ SSN _____

Address _____ City _____ State _____ Zip _____

Marital Status: Single _____ Married _____ Widowed _____ Separated _____Divorced _____ Sex: Female _____ Male ____

Race: (Please circle) White - Black/African American - American Indian/Alaska Native – Asian - Native Hawaiian/Other Pacific Islander

Other - More than 1 Race Preferred Language:_____ Ethnicity: Hispanic or Latino - Not Hispanic or Latino

Employer _____Occupation _____

Whom may we thank for referring you? _____Referring Physician_____

In case of an emergency who should be notified? _____ Phone # _____

Patient or Guarantor Email Address_____

Responsible Party for Minors

Name _____ DOB _____ SSN _____

Address _____ City _____ State _____ Zip _____

Primary Contact Number _____ Relationship to Patient _____

Primary Insurance Information

Insurance Company _____ Address _____

Member ID # _____ Group # _____ Phone # _____

Insured Party_____ DOB _____ SSN _____

Relationship to Patient _____ Phone # _____

Employer _____ Occupation _____

Secondary Insurance Information

Insurance Company _____ Address _____

Member ID # _____ Group # _____ Phone # _____

Insured Party_____ DOB _____ SSN _____

Relationship to Patient _____ Phone # _____

Employer _____ Occupation _____

Assignment of Benefits and Financial Agreement

I hereby give lifetime authorization for payment of insurance benefits to be made to **Adriatica Women's Health** and any assisting physicians, for the services rendered. I understand that I am financially responsible for all charges whether or not they are covered by insurance. In the event of default, I agree to pay all costs of collection, and reasonable attorney fees. I hereby authorize this healthcare provider to release all information necessary to secure payment of benefits. I further agree that a photocopy of this agreement shall be as valid as the original.

Date _____ Signature _____