

GATEWAY WOMEN'S CLINIC PATIENT INFORMATION FORM

CHART NUMBER _____ **ID CHECKED** _____ **DATE** _____

LAST NAME _____ **FIRST NAME** _____ **MIDDLE INITIAL** _____

HOME ADDRESS _____ **CITY** _____

STATE _____ **ZIP** _____ **EMAIL ADDRESS** _____

MAILING ADDRESS (IF DIFFERENT) _____

DR. YOU ARE SEEING TODAY _____ **YOUR FAMILY DOCTOR** _____

YOUR SS# _____ **DATE OF BIRTH** _____ **HOME PHONE** _____

EMPLOYER _____ **WORK PHONE** _____ **CELL/MESSAGE PHONE** _____

EMERGENCY CONTACT NAME _____ **RELATIONSHIP** _____ **PHONE** _____

INSURANCE INFORMATION:

SUBSCRIBER NAME _____ **RELATIONSHIP TO PATIENT** _____

INSURANCE NAME _____ **EFFECTIVE DATE** _____ **DO YOU HAVE A COPAY?** _____

SUBSCRIBER SS# _____ **SUBSCRIBER DATE OF BIRTH** _____

SUBSCRIBER PHONE NUMBER _____ **SUBSCRIBER ADDRESS** _____

SECOND INSURANCE INFORMATION:

SUBSCRIBER NAME _____ **RELATIONSHIP TO PATIENT** _____

INSURANCE NAME _____ **EFFECTIVE DATE** _____ **DO YOU HAVE A COPAY?** _____

SUBSCRIBER SS# _____ **SUBSCRIBER DATE OF BIRTH** _____

SUBSCRIBER PHONE NUMBER _____ **SUBSCRIBER ADDRESS** _____

WE WILL NEED TO MAKE A COPY OF YOUR INSURANCE CARD(S) AND IDENTIFICATION

I understand that my signature authorizes my insurance to pay benefits directly to Gateway Women's Clinic, but that I am ultimately financially responsible for all medical services rendered, including services provided by an outside lab or other facility.

I understand that my signature authorizes my treating physician at Gateway Women's Clinic to obtain lab results and other information necessary for treatment.

I have received and signed a copy of the OFFICE AND FINANCIAL POLICY,

I have received a copy of the NOTICE OF PRIVACY PRACTICES for this clinic.

SIGNED: _____

DATE: _____