CENTER FOR
WOMEN'S HEALTH
Comprehensive, personalized care you can trust

Patient Information

Date _____

Patient's Name _____ Age ____ DOB _____
SS# _____ Marital Status _____ Home Phone _____
Home Address _____
City, State, Zip _____
Employer (Indicate if student) _____
Work Phone _____ Address _____
Email address _____ Cell Phone _____
How did you hear about us? Family / Friend (name) _____ PPO list _____
Yellow Pages _____ Delta Style _____ News-Star _____
Spouse's/ Parent's Name _____
DOB _____ SS# _____ Home Phone _____
Employer _____ Work Phone _____
Address _____

Guarantor's Name _____
Address _____

Insurance Co _____ Policy # _____ Group # _____
Insured _____ DOB _____ Rel to patient _____

Please list an emergency contact not at your phone number or address:
Name _____ Relationship _____
Address _____ Phone _____

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I have received this practice's Notice of Privacy Practices written in plain language. The Notice provides in detail the uses and disclosures of my protected health information that may be made by this practice, my individual rights, how I may exercise these rights, and the practice's legal duties with respect to my information. I understand that this practice reserves the right to change the terms of its Notice of Privacy Practices, and to make changes regarding all protected health information resident at, or controlled by, this practice. I understand I can obtain this practice's current Notice of Privacy Practices on request.

_____
Patient's or Representative's Signature

Deductible and/or co-payment must be paid at the time of service. You will receive a monthly statement until your account is paid by your insurance company. It is your responsibility to see that your insurance pays in a timely manner. Any balance due after your insurance has paid is due at that time. *We do not bill.* We accept cash, checks, Visa, and Mastercard.

I authorize Dr. Coffman's office to release all information necessary to secure payment for my services at this office and for insurance payments to be made directly to the office.

_____
Patient's or Representative's Signature