

THE WOMEN'S PAVILION, P.S.C.

PATIENT AND INSURANCE INFORMATION

PATIENT'S NAME		Last,	First,	MI	MARITAL STATUS					DATE OF BIRTH	AGE	SOCIAL SECURITY NO.
					S	M	W	DIV	SEP			
STREET ADDRESS				CITY AND STATE					ZIP CODE	HOME PHONE NO.	CELL PHONE NO.	
PATIENT'S EMPLOYER				OCCUPATION (INDICATE OF STUDENT)					BUSINESS PHONE NO.		EXT. _____	
EMPLOYER'S STREET ADDRESS				CITY AND STATE					ZIP CODE			
SPOUSE'S NAME				DATE OF BIRTH					SOCIAL SECURITY NO.			
SPOUSE'S EMPLOYER				OCCUPATION (INDICATE OF STUDENT)					BUSINESS PHONE NO.		EXT. _____	
IN CASE OF EMERGENCY CONTACT				RELATIONSHIP TO PATIENT					PHONE NO.	PHONE NO.		

PRIMARY

SECONDARY

INSURANCE CO. NAME _____

INSURANCE CO. ADDRESS _____

INS. CO. CITY, STATE, ZIP _____

POLICYHOLDER'S NAME _____

DATE OF BIRTH _____

GROUP NO. _____

POLICY NO. _____

RELATIONSHIP TO PATIENT _____

INSURANCE AUTHORIZATION AND ASSIGNMENT (PLEASE READ AND SIGN)

I HEREBY AUTHORIZE THE WOMEN'S PAVILION, P.S.C., TO FURNISH INFORMATION TO INSURANCE CARRIERS CONCERNING MY ILLNESS AND TREATMENTS AND I HEREBY ASSIGN TO THE PHYSICIAN ALL PAYMENTS FOR MEDICAL SERVICES RENDERED TO MYSELF OR MY DEPENDENTS. I UNDERSTAND THAT I AM RESPONSIBLE FOR ANY AMOUNT NOT COVERED BY INSURANCE.

If your payment is delinquent more than sixty (60) days, all credit privileges may be canceled and collection efforts may ensue, in the event collection efforts become necessary, patient/guardian shall be responsible for all collection costs and fees, including reasonable attorney fees. Further, patient/guardian agrees for any disputes or claims that the venue or jurisdiction shall be in Owensboro, Daviess County, Kentucky.

Date _____ Patient Signature _____

Date _____ Responsible Party Signature _____