



Women's Specialty & Fertility Center

DATE _____ CHART# _____

PRIMARY CARE PHYSICIAN _____

OB/GYN(Fertility pts only) _____

REFERRED BY _____

PATIENT INFORMATION

(LASTNAME) (FIRSTNAME) (MIDDLE INITIAL)

MARRIED SINGLE WIDOWED

SEPARATED DIVORCED HOMEPHONE(____) _____ CELL # (____) _____

SOC. SEC.# _____ BIRTHDATE ____ / ____ / ____ AGE _____

ADDRESS _____

CITY _____ STATE _____ ZIP _____

EMPLOYER _____ CITY _____

WORK PHONE(____) _____ EMAIL _____

SPOUSE/SIGNIFICANT OTHER

(LASTNAME) (FIRSTNAME) (MIDDLE INITIAL)

SOC. SEC.# _____ BIRTHDATE ____ / ____ / ____ AGE _____

EMPLOYER _____ CELL PHONE(____) _____

SPOUSE/SIGNIFICANT OTHER EMAIL _____

IN CASE OF EMERGENCY PLEASE NOTIFY (Name of someone not living with you)

NAME _____ PHONE(____) _____

DO YOU HAVE MEDICAL INSURANCE?	YES	NO		
IF YES, WHO IS THE INSURANCE THROUGH?		SELF	SPOUSE	PARENT
	Primary Insurance		Secondary Insurance	
Insur. Name	_____		Insur. Name	_____
Subscriber	_____		Subscriber	_____
Policy#	_____		Policy#	_____
Group#	_____		Group#	_____
Ins Address	_____		Ins Address	_____
	_____			_____
Ins Phone#	_____		Ins Phone#	_____

ASSIGNMENT OF INSURANCE BENEFITS

CONSENT TO OBTAIN INFORMATION AND IRREVOCABLE ASSIGNMENT OF BENEFITS: THE UNDERSIGNED HEREBY AUTHORIZES THE PHYSICIAN, HIS/HER AGENTS OR REPRESENTATIVES, TO VERIFY ELIGIBILITY OF MEDICARE COVERAGE, TITLE XVIII OF THE SOCIAL SECURITY ADMINISTRATION AND/OR MEDI-CAL, TITLE XIX OF THE WELFARE AND INSTITUTIONS CODE. THIS AUTHORIZATION AND CONSENT ALSO APPLIES TO ANY OTHER THIRD PARTY PAYER AS DETERMINED TO PROVIDE MEDICAL EXPENSE COVERAGE ON MY BEHALF INCLUDING HEALTH INSURANCE COVERAGE. I HEREBY IRREVOCABLY ASSIGN TO THE PHYSICIAN, TO THE EXTENT PERMITTED BY LAW, ALL RIGHTS AND BENEFITS PAYABLE ON MY BEHALF FROM ANY ABOVE MENTIONED COVERAGE PROGRAM(S). I FURTHER UNDERSTAND THAT I AM PRIMARILY RESPONSIBLE FOR ALL PHYSICIAN CHARGES REGARDLESS OF ANY ASSIGNMENT OF BENEFITS. IF THE INSURANCE DENIES COVERAGE OR DOES NOT PAY IN A REASONABLE TIME, I AGREE TO MAKE SATISFACTORY ARRANGEMENTS TO SETTLE THE ACCOUNT WITH THE PHYSICIAN AT THE PHYSICIAN'S REQUEST. I FURTHER ACKNOWLEDGE THAT ANY PAYABLE BENEFITS, WHEN RECEIVED BY THE PHYSICIAN, WILL BE CREDITED TO MY ACCOUNT, ACCORDING TO THE ABOVE ASSIGNMENT. THE UNDERSIGNED CERTIFIES THAT HE/SHE HAS READS THE FOREGOING, RECEIVED A COPY THEREOF, AND IS THE PATIENT, THE PATIENT'S LEGAL REPRESENTATIVE, OR IS DULY AUTHORIZED BY THE PATIENT'S GENERAL AGENT TO EXECUTE THE ABOVE AND ACCEPTS ITS TERMS.

FINANCIAL DISCLOSURE

WOMEN'S SPECIALTY AND FERTILITY CENTER (WSFC) IS A MEMBER OF COMMUNITY FOUNDATION MEDICAL GROUP (CFMG) AND I MAY RECEIVE A BILL FROM CFMG FOR SERVICES PROVIDED BY WSFC AND/OR THE GROUP'S PROVIDERS.

PATIENT/PARENT/GUARDIAN/CONSERVATOR

DATE

IF OTHER THAN PATIENT, INDICATE RELATIONSHIP

WITNESS