Women's Health Care Group of PA
Great Valley OB/GYN Division

Patient Name: _____ Social Security Number: _____
First Name MI Last Name If applicable, I prefer to be called: _____ Date of Birth: _____

Ethnicity: ( ) Decline to answer ( ) Hispanic/Latina ( ) Non- Hispanic/Latina ( ) Unknown
Race: ( ) American Indian/Alaskan Native ( ) Asian ( ) Black/African American ( ) Caucasian ( ) Decline to answer ( ) Native Hawaiian/Pacific Islander
( ) Other:_____ ( ) Unknown

Marital Status: ( ) Single ( ) Married ( ) Widowed ( ) Domestic Partner ( ) Separated ( ) Divorced ( ) Decline to answer

Primary Language if not English: _____
Address 1: _____
Address 2: _____ Home Phone: _____
City, State, Zip: _____ Other Phone: _____
Employer: _____ Empl. Status: ( ) Employed Full-Time ( ) Employed Part-Time
Address 1: _____ ( ) Retired ( ) Student ( ) Homemaker ( ) Disabled
Address 2: _____ ( ) Self-Employed ( ) Unemployed
City, State, Zip: _____ Work Phone: ( ) _____

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Emergency Contact: _____ Relationship to patient: _____
Address 1: _____ Home Phone: _____
Address 2: _____ Work Phone: _____
City, State, Zip: _____

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Insurance Information
PRIMARY INSURANCE:

_____

ID#: _____ Group/Policy#: _____
Subscriber's Name: _____ Subscriber's DOB & Sex: _____
Relationship to Patient: _____ Effective Date: _____
Subscriber's Employer:

_____

SECONDARY INSURANCE:

_____

ID#: _____ Group/Policy#: _____
Subscriber's Name: _____ Subscriber's DOB & Sex: _____
Relationship to Patient: _____ Effective Date: _____
Subscriber's Employer:

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Commercial ASSIGNMENT OF INSURANCE BENEFITS - I hereby authorize payment directly to Women's Health Care Group of PA for medical benefits including any Major Medical benefits otherwise payable to me under the terms of my policy but not to exceed the balance due to physicians. In making this assignment, I understand and agree that I am financially responsible to the above party for charges not paid under this insurance policy. I permit a copy of this authorization to be used in place of the original.

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General RELEASE OF INFORMATION - Women's Health Care Group of PA may disclose any or all parts of my clinical records to my insurance company or companies, or in the case of Worker's Compensation claims, to my past or present employer(s), for purposes of satisfying charges billed by Women's Health Care Group of PA and/or its physicians. This authorization does not cover requests from other parties seeking information regarding my account.

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GUARANTEE OF ACCOUNT - Women's Health Care Group of PA
For and in consideration of services rendered by Women's Health Care Group of PA to the below named patient, the undersigned (jointly and severally if more than one) guarantees payment of all charges incurred for said patient in accordance with the policy of payments of such bills.

THE UNDERSIGNED CERTIFY THAT EACH HAS READ AND UNDERSTANDS THE ABOVE TERMS AND CONDITIONS.

Patient or Guardian Signature Date