Last Name _____ First_____ M_____

Address _____

City _____State _____Zip Code_____

Home phone_____ Cell Phone_____

Email address_____

Social Security # _____ Date of Birth _____

Race (circle): Hisp./White/Black/Asian/Other_____ Status (circle): married/single/child

What location are you being seen? (CIRCLE) Goodyear / Avondale/ Laveen

Name of Doctor you have chosen (CIRCLE): Dr. Howard /Dr. Sun /Dr. Sta Maria/ Dr. Adenle

How did you hear about us? _____

Primary Insurance Information

Insurance company _____ Are you the policy holder? Y/N

Policy holder's name _____ Group # _____

Policy ID # _____ Relationship to you _____

Policy holder's date of birth _____ Social Security #_____

Employer _____

Have you applied for State Medicaid/AHCCCS? Y/N If so, please provide us with a letter from AHCCCS stating you are pending coverage or provide us with information below.

Secondary Insurance Information

Insurance company _____

Policy holder's name _____ Group # _____

Policy ID #_____ Relationship to you _____

Policy holders date of birth _____

Do you have any other insurance you have not listed above? Y/N Please be aware, if you do not provide us with all of your insurance plan(s) information, you will be responsible for any outstanding or denied claims.

Payment Responsibility

If your insurance does not cover the office visit, procedure or surgery provided, who will be liable for payment?

Name _____Address_____

Phone number _____Relationship to you _____

I have read and agreed to the terms and conditions of all consents, Practice Information and Financial Responsibilities.

PLEASE INITIAL

_____ Consent for Use or Disclosure of Health Information

_____ Patient Insurance and Financial Responsibilities

_____ Palm Valley Women's Care Practice Information

I authorize release of any medical information necessary to process Medicare and or any insurance claims. I authorize payment of medical benefits to Palm Valley Women's Care. I understand I am responsible for any deductible, co pays, coinsurance or noncovered services. I also understand that I will provide all updated demographic and insurance information immediately. Any collections or attorney fees will also be my responsibility.

Patient name printed _____Date _____

Patient signature _____Date_____

Witness_____ Date _____