VISALIA WOMEN'S SPECIALTY MEDICAL GROUP, INC.

CHART #

PATIENT INFORMATION CONFIDENTIAL

*** PLEASE PRINT ***

NAME _____ ❑ SINGLE ❑ MARRIED ❑ DIVORCED ❑ WIDOWED

ADDRESS _____ CITY _____ STATE_____ ZIP _____

EMAIL ADDRESS _____ SEX ❑ M ❑ F

BEST PHONE NO. TO REACH YOU _____ CELL PHONE _____

BIRTHDATE _____ SSN _____/_____/_____

PATIENT'S EMPLOYER _____ WORK PHONE _____

BUSINESS ADDRESS _____ CITY _____ STATE_____ ZIP _____

SPOUSE'S NAME _____ EMPLOYER _____ WORK PHONE _____

PERSON TO CONTACT IN CASE OF EMERGENCY _____ PHONE _____

HOW DID YOU FIND OUT ABOUT US? _____

ANY ALLERGIES? ❑ Yes ❑ No IF YES, PLEASE LIST: _____

PRIMARY INSURANCE INFORMATION

EFFECTIVE DATE _____ RELATIONSHIP TO PATIENT _____

SUBSCRIBER NAME _____ SSN _____/_____/_____

BIRTHDATE _____ EMPLOYER _____ WORK PHONE _____

ID NUMBER _____ GROUP # _____ PLAN # _____

INSURANCE COMPANY NAME _____ FAMILY COVERAGE ❑ Yes ❑ No

IS THERE ADDITIONAL INSURANCE COVERAGE? ❑ Yes ❑ No IF YES COMPLETE THE FOLLOWING:

SECONDARY/SUPPLEMENTAL INSURANCE

EFFECTIVE DATE _____ RELATIONSHIP TO PATIENT _____

SUBSCRIBER NAME _____ SSN _____/_____/_____

BIRTHDATE _____ EMPLOYER _____ WORK PHONE _____

ID NUMBER _____ GROUP # _____ PLAN # _____

INSURANCE COMPANY NAME _____ FAMILY COVERAGE ❑ Yes ❑ No

I AUTHORIZE ANY HOLDER OF MEDICAL INFORMATION ABOUT ME TO RELEASE INFORMATION TO THIRD PARTY PAYERS IN ORDER TO DETERMINE BENEFITS FOR SERVICES PROVIDED. I AUTHORIZE PAYMENT BY MY THIRD PARTY PAYOR DIRECTLY TO VISALIA WOMEN'S SPECIALTY MEDICAL GROUP, INC. I PERMIT A COPY OF THIS AUTHORIZATION TO BE USED AS THE ORIGINAL.

I AUTHORIZE THE PHYSICIANS AND STAFF OF VISALIA WOMEN'S SPECIALTY MEDICAL GROUP, INC. TO RENDER MEDICAL TREATMENT, EXCEPT FOR MEDICAL EMERGENCY, ANY PATIENT, GUARDIAN WHO REFUSES TO COMPLETE AND SIGN THIS AUTHORIZATION FOR TREATMENT MAY BE DENIED SERVICE. I HAVE READ AND AGREED TO THE ABOVE CONDITIONS.

I verify that the information given above is correct.

SIGNATURE	DATE	SIGNATURE	DATE
SIGNATURE	DATE	SIGNATURE	DATE
SIGNATURE	DATE	SIGNATURE	DATE
SIGNATURE	DATE	SIGNATURE	DATE

****** ATTACH A COPY OF ALL INSURANCE CARDS ******