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: _____

RESPONSIBLE PARTY FOR PAYMENT (IF PATIENT IS MINOR):

NAME _____
LAST FIRST MIDDLE

RELATIONSHIP TO PATIENT _____ SSN _____/_____/_____

ADDRESS _____ PHONE _____

EMPLOYER _____ EMPLOYER PHONE _____

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

FINANCIAL AGREEMENT AND AUTHORIZATION FOR TREATMENT: I authorize treatment of the person named above and agree to pay all fees and charges for such treatment. I agree to pay all charges for me and members of my family shown by statements promptly upon presentment thereof, unless credit arrangements are agreed upon. Charges shown by statements are agreed to be correct and reasonable unless protested in writing within thirty days of billing date. In the event legal action should become necessary to collect an unpaid balance due for medical services rendered to me or my family, I/we agree to pay reasonable attorney's fees or other such costs as the Court determines proper.

IT IS AGREED THAT PAYMENTS WILL NOT BE DELAYED OR WITHHELD BECAUSE OF ANY INSURANCE COVERAGE OR THE PENDENCY OF CLAIMS THERE ON, AND ALL PROCEEDS OF INSURANCE ARE ASSIGNED TO THIS OFFICE WHERE APPLICABLE, BUT WITHOUT THEIR ASSUMING RESPONSIBILITY FOR THE COLLECTION THEREOF. (A copy of this assignment is as valid as the original.)

AGREEMENT: The above information is for the purpose of obtaining credit and is warranted to be true. I authorize the creditor or his agent to make a credit investigation, including employment verification.

I AUTHORIZE VISALIA WOMENS SPECIALTY MEDICAL GROUP, INC. TO FURNISH INFORMATION TO INSURANCE CARRIERS CONCERNINGMYILLNESS AND TREATMENTS, AND HEREBY ACKNOWLEDGE RECEIPT OF A COPY OF THIS FORM. I HEREBY ACKNOWLEDGE THAT I HAVE BEEN OFFERED A COPY OF THIS MEDICAL PRACTICE'S NOTICE OF PRIVACY PRACTICES.

I verify that the information given above is correct.

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

_____
SIGNATURE DATE

_____
NAME RELATIONSHIP TO MINOR (If applicable)