PATIENT INFORMATION

[ ] Southwest Women's Care, P.C. 16611 South 40th Street, Suite 180 Phoenix AZ 85048
[ ] Southwest Women's Care, P.C. 2204 South Dobson, Suite 202 Mesa, AZ 85202

[ ] Kimberly Balk, MD [ ] Robert Grayson, MD [ ] Laura Kimbro, DO [ ] Stephanie Mayes, MD
[ ] Jamal Mourad, DO [ ] Mo Vaziri, MD [ ] Amy Williamson, MD [ ] Richard Wilson, MD

[ ] T. Simpson, WHNP

PATIENT NAME: ____________________ HOME: ____________WORK: ____________ CELL: ____________

BILLING ADDRESS: ____________________ CITY, STATE, ZIP: ____________________

PERMANENT ADDRESS: ____________________ CITY, STATE, ZIP: ____________________

PATIENT SS#: ____________________ SEX ______M ______F BIRTHDATE: ____________ AGE: ________

IS PATIENT: ____Single ____Married ____Other IS PATENT ____Employed ____Full-Time Student ____Part-Time Student ____ Other

EMPLOYER (NAME, ADDRESS & PHONE #: ____________________

RESPONSIBLE PARTY: ____________________ HOME PHONE #: ____________ BUSINESS PHONE: ____________

RESP. PARTY SS#: ____________ RELATIONSHIP TO PATIENT:______SELF ______SPOUSE ______CHILD ______OTHER

SPOUSE OR NEAREST RELATIVE (NAME, ADDRESS & PHONE #):____________________

SPOUSE OR NEAREST RELATIVE EMPLOYER (NAME, ADDRESS & PHONE #): ____________________

REFERRING PHYSICIAN (NAME & ADDRESS): ____________________
(Or how did you hear about us)
PRIMARY CARE PHYSICIAN (NAME & ADDRESS):____________________

IS INJURY RELATED TO AN ACCIDENT? ____NO ____ YES ____ Auto Accident ____Job Related Injury DATE OF INJURY: ____________

WHAT ARE YOU BEING SEEN FOR TODAY: ____________________ FIRST DATE OF SYMPTOMS: ____________

ALLERGIES: ____________________ ARE YOU PREGNANT: ____YES ____NO

INSURANCE INFORMATION

PRIMARY INSURANCE
INSURANCE CO. NAME: ____________________

INS. CO. ADDRESS: ____________________

POLICY HOLDER NAME: ____________________

RELATIONSHIP TO PATIENT: ____________________

EMPLOYER: ____________________

POLICY #: ____________ GROUP/CLAIM #: ____________

POLICY HOLDER SEX: ____M ____F BIRTHDATE: ____________

COPAY $:__________ DEDUCT $: __________ VERIFIED: __________

SECONDARY INSURANCE
INSURANCE CO. NAME: ____________________

INS. CO. ADDRESS: ____________________

POLICY HOLDER NAME: ____________________

RELATIONSHIP TO PATIENT: ____________________

EMPLOYER: ____________________

POLICY #:____________GROUP/CLAIM #: ____________

POLICY HOLDER SEX: ____M ____F BIRTHDATE: ____________

COPAY $: __________ DEDUCT $:__________ VERIFIED: __________

AUTHORIZATION TO RELEASE INFORMATION:
I hereby authorize this physician/clinic to release information to my insurance company required in the course of my examination or treatment which could include HIV, communicable disease or drug abuse information.
AUTHORIZATION TO PAY:
I hereby authorize payment directly to the business office of this physician/clinic for the surgical and/or medical benefits, if any otherwise payable to me for services.
I understand that I am financially responsible for the charges not covered by my insurance.

____________________________________ ______________________
SIGNED (PATIENT OR GUARDIAN, IF PATIENT IS A MINOR) DATE