



MADISON
WOMEN'S
CLINIC

OB/GYN PATIENT INFORMATION FORM

Patient Name			Marital Status	
Street Address		City	State	Zip
Home Phone	Work Phone		Cell Phone	
Date of Birth		Social Security Number		
Any other last names used?		E-mail Address		
Patient Employer		Patient Employer Phone		
Spouse Name		Parent Name if Minor		
Spouse/Parent Birth Date		Spouse/Parent Employer Phone		
Home Address (if BYU-I student)				

NEAREST RELATIVE/FRIEND NOT RESIDING AT THE SAME RESIDENCE AS YOURS:

Name		Phone		
Address	City	State	Zip	

INSURANCE INFORMATION/ Applying Idaho Medicaid YES ___ NO ___

Insurance Company		Policy Holder's Name		
Relationship	Birth Date	Social Security #		
Member ID Number	Group Number	Employer		
Additional Insurance Company		Policy Holder's Name		
Relationship	Birth Date	Social Security #		
Member ID Number	Group Number	Employer		

Physician Referred by: _____

AUTHORIZATION FOR RELEASE OF INFORMATION – I hereby authorize this practice to furnish any medical information requested by insurance companies with whom I have coverage or any public agency which may be assisting in payment of my care.

ASSIGNMENT OF BENEFITS – I hereby authorize payment directly to this practice of benefits otherwise payable to me including major medical insurance and payment of surgical or medical benefits, but not to exceed the charges for these services. I understand that I am financially responsible for charges not covered by this assignment.

GUARANTEE OF ACCOUNT – For services furnished by Madison Women's Clinic, I hereby guarantee the payment of all accounts for services rendered. For payment of said accounts for services I hereby waive all claims of exemption under the State of Idaho and agree to pay, if necessary, all costs of collection, including attorney's fees.

Signature _____

Date _____