WOMEN'S | Health Care Group of PA
Valley Forge OB/GYN Division

Patient Name: _____
Last Name First Name MI

Other Name: _____

Sex: ( ) M ( ) F

Martial Status: ( ) Single ( ) Married ( ) Widowed ( ) Domestic Partner
( ) Separated ( ) Divorced ( ) Other

Address 1: _____
Address 2: _____
City, State, Zip: _____

Social Security Number: _____

Date of Birth: _____

Race: ( ) African American ( ) Asian/Oriental ( ) Caucasian ( ) Hispanic
( ) Native American ( ) Other ( ) Unknown ( ) Decline

Ethnicity: ( ) Hispanic or Latino ( ) Not Hispanic or Latino ( ) Decline

Primary Language:_____

Home Phone: ( ) _____
Other Phone: ( ) _____

Employer: _____
Address 1: _____
Address 2: _____
City, State, Zip: _____

Emp. Status: ( ) Employed Full-Time ( ) Employed Part-Time
( ) Retired ( ) Student ( ) Homemaker ( ) Disabled
( ) Self-Employed ( ) Unemployed

Work Phone: ( ) _____

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Emergency Contact: _____
Address 1: _____
Address 2: _____
City, State, Zip: _____

Patient's Relationship: _____
Home Phone: ( ) _____
Work Phone: ( ) _____

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Insurance Information

PRIMARY INSURANCE: _____
ID#: _____
Subscriber's Name: _____
Relationship to Patient: _____
Subscriber's Employer: _____

Group/Policy#: _____
Subscriber's DOB & Sex: _____
Effective Date: _____

SECONDARY INSURANCE: _____
ID#: _____
Subscriber's Name: _____
Relationship to Patient: _____
Subscriber's Employer: _____

Group/Policy#: _____
Subscriber's DOB & Sex: _____
Effective Date: _____

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Commercial **ASSIGNMENT OF INSURANCE BENEFITS**-I hereby authorized payment directly to Women's Health Care Group of PA for medical benefits including any Major Medical benefits other wise payable to me under the terms of my policy but not to exceed the balance due to physicians. In making this assignment, I understand and agree that I am financially responsible to the above party for charges not paid under this insurance policy. I permit a copy of this authorization to be used in place of the original.

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General **RELEASE OF INFORMATION**-Women's Health Care Group of PA may disclose any or all parts of my clinical records to my insurance company or companies, or in case of Worker's Compensation claims, to my past or present employer(s), for purpose of satisfying charges billed by Women's Health Care Group of PA and/or it's physicians. This authorization does not cover request from other parties seeking information regarding my account.

GUARANTEE OF ACCOUNT- Women's Health Care Group of PA

For and in consideration of services rendered by Women's Health Care Group of PA to below named patient, the undersigned (jointly and severally if more than one) guarantees payment of all charges incurred for said patient in accordance with the policy of payments of such bills.

THE UNDERSIGNED CERTIFIES THAT EACH HAS READ AND UNDERSTANDS THE ABOVE TERMS AND CONDITIONS.

_____
Patient Signature Date

_____
Patient's Agent Representative and Guarantor Signature Date