



THE WOMEN'S HEALTHCARE GROUP
1693 South Queen Street
York, Pennsylvania 17403
717/845-1621 Fax: 717/854-6939
www.womenshealthcaregroup.com

Your Name _____ Social Security No. _____
(first) (middle) (last)

Maiden/Other Name _____ Marital Status _____ Age _____ Date of Birth ____/____/____

Your present address _____
(street) (city) (state) (zip code)

Home phone # _____ Work phone # _____ Cell phone # _____

Your Employer _____

Your Occupation _____ **Circle One** → Full-time Part-time Self Employed

Husband's Name _____ **Husband's Soc. Sec. No.** _____ **Husband's Age** _____

Husband's address (if different from above) _____

Husband's Date of Birth ____/____/____ **Husband's Employer** _____

Husband's Occupation _____ **Husband's Work phone #** _____
Circle One → Full-time Part-time Self Employed

Name of your family doctor _____ How were you referred to our Practice? _____

Emergency contact (not husband) _____ Relationship _____ Phone # _____

**** This section must be completed in order for us to submit your claims to your insurance company: ****

Primary Insurance

Policyholder's Name: _____
 Name of Ins. Co.: _____
 Subscriber's Birth date: _____
 Subscriber's SSN: _____
 Subscriber's Employer: _____

Secondary Insurance

Policyholder's Name: _____
 Name of Ins. Co.: _____
 Subscriber's Birth date: _____
 Subscriber's SSN: _____
 Subscriber's Employer: _____

Responsible Party name (for billing purposes) _____ Relationship _____

Responsible Party address (if different from above) _____

Responsible Party Home phone # _____ **Responsible Party Work phone #** _____

PLEASE SHOW THE RECEPTIONIST YOUR INSURANCE CARD (S).

By my signature below, I authorize the release of any medical or other information deemed necessary by The Women's Healthcare Group including the transfer of all or a portion of my medical records to support medically necessary referrals to other health care providers.

By my signature below, I authorize payment of medical benefits to The Women's Healthcare Group.

By my signature below, I have read and understand the Financial Policy on the reverse side of this form.

Signature: _____ **Date:** _____

****Please read Financial Policy on reverse side****

(Office will attach copy of Insurance Card)