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

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 # _____

E-mail address _____

Your Employer _____Your Occupation_____ **Circle One** →Full-time Part-time Self Employed

Significant Other's Name _____ Soc. Sec. No._____ Age _____
Significant Other's address (if different from above) _____
Significant Other's Date of Birth ____/____/_____ **Cell** phone #_____
Significant Other's Occupation _____**Employer** _____
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)

revised 7/2017