PATIENT INFORMATION FORM

METRO PARTNERS IN WOMEN'S HEALTH

Today's Date: _____

Patient Name: _____ Social Security #: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: Home: _____ Office: _____ Cell: _____

Date of Birth: _____ Marital Status: _____

Email Address: _____

Race: _____ Ethnicity: _____ Language: _____

Employer: _____ Occupation _____

Primary Care Physician Name: _____

Messages regarding my results/treatment may be left on **my cell or home phone**: O Yes O No
Messages regarding my results/treatment may be left on **my work voice mail**: O Yes O No
Messages regarding my results/treatment may be left **with my spouse/parent**: O Yes O No

Pharmacy Name: _____ Pharmacy #: _____

Pharmacy Address: _____

Emergency Contact: _____ Relationship: _____

Phone: Home: _____ Office: _____ Cell: _____

INSURANCE INFORMATION

Insurance: _____ Employer: _____

Subscriber Name: _____ Subscriber Date of Birth: _____

Subscriber Address: _____

City _____ State: _____ Zip: _____

I have provided MPIWH with a copy of my Advance Directive: O Yes O No
If No, I have been offered information regarding Advance Directives: O Yes O No

I hereby authorize and provide consent to Metro Partners in Women's Health Providers to furnish the requested diagnostic services and/or treatment and bill for services rendered.

I authorize payment of medical benefits to Metro Partners in Women's Health for services provided. I understand that if my insurance company does not reimburse services, I will be responsible.

Patient/Authorized Person Signature: _____ **Date:** _____

****Authorization valid for 1 year from date of signature****

v.JAN23