SEASHORE WOMEN'S HEALTH PATIENT QUESTIONNAIRE

PATIENT INFORMATION

PATIENT NAME		
DOB/AGE /	SSN	PHONE
CURRENT ADDRESS		
CITY	STATE	ZIP
EMAIL	PRIMARY PHONE/TYPE /	SECONDARY PHONE/TYPE /

EMPLOYMENT/SCHOOL INFORMATION

PATIENT EMPLOYER/SCHOOL NAME (IF APPLICABLE)		
EMPLOYER/SCHOOL ADDRESS		OCCUPATION
CITY	STATE	ZIP
WORK PHONE	WORK/SCHOOL EMAIL	FAX

RESPONSIBLE PARTY (IF OTHER THAN PATIENT)

NAME /RELATIONSHIP TO PATIENT		
ADDRESS		PHONE
CITY	STATE	ZIP
EMERGENCY CONTACT NAME		
RELATIONSHIP	PRIMARY PHONE/TYPE	SECONDARY PHONE/TYPE

PRIMARY INSURANCE INFORMATION

PRIMARY INSURANCE	EFFECTIVE DATE	ID/GROUP #
POLICY HOLDER NAME	RELATIONSHIP TO INSURED	POLICY HOLDER DOB
POLICY HOLDER EMPLOYER NAME	EMPLOYER PHONE NUMBER	POLICY HOLDER SSN

SECONDARY INSURANCE

SECONDARY INSURANCE	EFFECTIVE DATE	ID/GROUP #
POLICY HOLDER NAME	RELATIONSHIP TO INSURED	POLICY HOLDER DOB
POLICY HOLDER EMPLOYER NAME	EMPLOYER PHONE NUMBER	POLICY HOLDER SSN

AUTHORIZATION & CONSENT

I HEREBY AUTHORIZE THIS PRACTICE TO RELEASE INFORMATION TO MY INSURANCE COMPANY. I ALSO AUTHORIZE THIS PRACTICE TO RELEASE MY MEDICAL INFORMATION TO ANY HOSPITAL, PHYSICIAN OR PROVIDER FOR REFERRAL PURPOSES. I AUTHORIZE PAYMENT OF MEDICAL BENEFITS DIRECTLY TO THE PHYSICIAN AND I AUTHORIZE THE USE OF THIS SIGNATURE ON ALL INSURANCE CLAIMS FORMS. I AUTHORIZE A COPY OF THIS AUTHORIZATION TO BE USED IN PLACE OF THE ORIGINAL.

SIGNATURE OF APPLICANT:	DATE: