PATIENT INFORMATION (Please Print) *PLEASE PROVIDE US WITH A COPY*

Patient's First & Last Name	SS Number	Maiden Name	Birth date	Age	Race

Mailing Address	City & State	Zip	Home Phone ( )

Cell Phone ( )	Marital Status	Patient's Employer	Occupation	Business Phone ( )

Preferred Pharmacy & City	Employer's Mailing Address	Employer's City, State, Zip

Name of Spouse	Spouse SS#	Spouse Date of Birth	Spouse Employer

Spouse Employer's Phone & Address	Emergency Contact Name	Emergency Contact Phone Number ( )

Were you referred to this office?	If yes, who referred you to this office? Please check
___ Yes ___ No	__ Friend or Relative_____ __ Patient _____ __ Physician _____

If the patient is under 18 years of age or is still covered by the parent's insurance (i.e. student), please complete the following information. As of June 29, 1988 the Ohio law state that in families where both parent have family coverage, the primary health-care plan for the children will be that of the parent whose birthday falls earliest in the year.

Father's Name	Date of Birth	Father's SS #
Employer's Name and Street Address	City, State, Zip	Employer Phone Number
Mother's Name	Date of Birth	Mother's SS #
Employer's Name and Street Address	City, State, Zip	Employer Phone Number

Office Use Only:

Complaint or Diagnosis:
Doctor's Name:
Type of Test Ordered:

OFFICE CHARGES

CHARGES FOR OFFICE VISITS ARE PAYABLE AT COMPLETION OF VISIT. THE OFFICE WILL GIVE YOU A FORM YOU CAN SUBMIT TO YOUR CARRIER FOR REIMBURSEMENT.

INSURANCE AUTHORIZATION AND ASSIGNMENT

I hereby authorize Ashland Center for Women's Health to furnish information to insurance carriers concerning my treatment and I hereby assign to the physicians and/or providers all payments for medical services rendered to myself or my dependents. I understand that I am responsible for any amount not covered by insurance.

Signature: _____ Date: _____

CONSENT FOR TREATMENT

I consent to receive treatment from the providers of Ashland Center for Women's Health.

Patient Signature: _____ Date: _____

Parent Signature, if patient is a minor: _____