## Women's Health Care Group of PA Great Valley OB/GYN Division

Patient Name:	Social Security Number:
First Name MI Last Name If applicable, I prefer to be of	called: Date of Birth:
Ethnicity: ( ) Decline to answer ( ) Hispanic/Latina ( ) Non- Hispanic Race: ( ) American Indian/Alaskan Native ( ) Asian ( ) Black/African American ( ) Other:	c/Latina ( ) Unknown n ( ) Caucasian ( ) Decline to answer ( ) Native Hawaiian/Pacific Islander
Marital Status: ( ) Single ( ) Married ( ) Widowed ( ) Domestic Partner (	( ) Separated ( ) Divorced ( ) Decline to answer
Primary Language if not English:	
Address 1:	
Address 2:	Home Phone:
City, State, Zip:	Other Phone:
Employer:	Empl. Status: ( ) Employed Full-Time ( ) Employed Part-Time
Address 1:	() Retired () Student () Homemaker () Disabled
Address 2:	( ) Self-Employed ( ) Unemployed
city, State, Zip:*******************************	Work Phone: ( )
Emergency Contact:	Relationship to patient:
Address 1:	Home Phone:
Address 2:	Work Phone:
City, State, Zip:	
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Insurance Information PRIMARY INSURANCE:	
ID#:	Group/Policy#:
Subscriber's Name:	Subscriber's DOB & Sex:
Relationship to Patient:	Effective Date:
Subscriber's Employer:	
SECONDARY INSURANCE:	
	Group/Policy#:
Subscriber's Name:	Subscriber's DOB & Sex:
Relationship to Patient:	Effective Date:
Subscriber's Employer:	
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	hereby authorize payment directly to Women's Health Care Group
of PA for medical benefits including any Major Medical benefits of	otherwise payable to me under the terms of my policy but not to
exceed the balance due to physicians. In making this assignment, I	
responsible to the above party for charges not paid under this insurused in place of the original.	ance policy. I permit a copy of this authorization to be
General RELEASE OF INFORMATION - Women's Health Ca	
records to my insurance company or companies, or in the case of V employer(s), for purposes of satisfying charges billed by Women's authorization does not cover requests from other parties seeking in	Worker's Compensation claims, to my past or present s Health Care Group of PA and/or its physicians. This formation regarding my account.
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GUARANTEE OF ACCOUNT - Women's Health Care Group of For and in consideration of services rendered by Women's Health undersigned (jointly and severally if more than one) guarantees paraccordance with the policy of payments of such bills.	Care Group of PA to the below named patient, the
THE UNDERSIGNED CERTIFY THAT EACH HAS READ AND CONDITIONS.	D UNDERSTANDS THE ABOVE TERMS AND

Date

Patient or Guardian Signature