

# ALL ABOUT WOMEN OF CHRISTIANA CARE, INC.

## PATIENT INFORMATION RECORD (PLEASE PRINT)



PATIENT INFORMATION					
Last Name:		First Name:		M.I.:	
Street Address:		Apt #:	City, State, Zip:		
Date of Birth:	Age:	Social Security #:	Marital Status: (Circle) Single / Mar / Div / Widow	LMP:	
Home Phone #:	Work Phone #:	Cell Phone #:	Drug Allergies:		
Email:					
RESPONSIBLE PARTY'S INFORMATION (BILL TO)					
(If patient is under 18 yrs old, please complete with parent/guardian's information.)					
Last Name:		First Name:		M.I.:	
Street Address:		City, State, Zip:			
Date of Birth:	Social Security #:		Contact Phone #:		
INSURANCE INFORMATION					
Primary Insurance:				Copay \$:	
Policyholder's Name:	Social Security #:	Date of Birth:	Policy #:	Group #:	
Patient's Relationship to Insured:	<input type="checkbox"/> Self	<input type="checkbox"/> Spouse	<input type="checkbox"/> Child	<input type="checkbox"/> Other:	Effective Date:
Secondary Insurance (if applicable):				Copay \$:	
Policyholder's Name:	Social Security #:	Date of Birth:	Policy #:	Group #:	
Patient's Relationship to Insured:	<input type="checkbox"/> Self	<input type="checkbox"/> Spouse	<input type="checkbox"/> Child	<input type="checkbox"/> Other:	Effective Date:

**Authorization to Release Medical Information:** I authorize All About Women of Christiana Care, Inc. to disclose my health and medical information to the following:

\_\_\_\_\_

**HIPAA:** I understand that All About Women of Christiana Care, Inc. will protect my personal information to the extent of the law. I have received a copy of the office's HIPAA privacy practices.

\_\_\_\_\_  
Signature

I request that payment of authorized Insurance Carrier (or) Medicare listed above benefits be made either to me or on my behalf to the name of provider or service and (or) supplier for any services furnished to me by that provider of service and (or) supplier. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related service.

Signature: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_ Date: \_\_\_\_\_