Associates in Womens Health, L.L.C.

FORMS CAN BE COMPLETED ON OUR WEBSITE: **www.awhomaha.com**

Account # _____ Where options are listed please **circle only one answer**.

Date of Appointment	**Reason for Appointment**	**Appointment with** Nabity / Bossert / Simmons / Pearsall / Evans / Sullivan
Referring Physician	**Family Physician (if different than Referring Dr)**	
Pharmacy Name	**Pharmacy Address, City, State**	**Pharmacy Phone #**
Patient's Name: First Name, Middle Initial, Last Name (please print) Goes By	**Date of Birth**	**Age** / **Soc. Sec. #**
Race: White-Caucasian / Black-African-American / American Indian-Alaska Native / Asian / Nat. Hawaiian-Pacific Islander / Declined / Unknown / Other: _____	**Ethnicity:** Declined / Hispanic-Latino / Not Hispanic-Latino	
Primary Language: English / Spanish / Arabic / Chinese / Filipino / French / German / Greek / Hindi / Hmong / Italian / Japanese / Korean / Lithuanian / Polish / Portuguese / Russian / Somali / Vietnamese/ Declined / N/A / Other: _____		
Religion: Buddhist / Catholic / Hindu / Islam / Jehovah's Witness / Jewish / Mormon / Protestant-Methodist/Lutheran/Baptist / N/A / Unknown		
Marital Status: Single / Married / Separated / Divorced / Widowed / Annulled / Common Law / Domestic Partner / Living Together / Other		
Street Address (include apt#)	**City, State and Zip Code + 4 digits**	
Home phone #	**Work Phone # (include ext.)**	**Cell phone #** / **Primary Phone #** cell / home / work
Fax #	**Pager #**	**Email address:**

EMPLOYMENT INFORMATION

Patient's Employer	**Status:** Full-time / Part-time / Self-employed / Retired / Unemployed / Temporary Unemployed / Leave of Absence / Contract /Active Military Duty / Part-time Student / Full-time Student / Other	
Employer's Street Address	**City, State and Zip Code**	**Occupation** (indicate if student)

EMERGENCY CONTACT INFORMATION

1st Emergency Contact (First Name, M.I., Last Name)	**Relationship**	**Date of Birth**	**Cell Phone #**
Emergency Contact's Employer	**Occupation (indicate if student)**		**Work Phone #**

2nd Emergency Contact (someone other than your spouse)	**Relationship**	**Daytime Phone #**

INSURANCE INFORMATION

Person responsible for Payment (if not the patient)	**Street Address, City, State and Zip Code**	
Primary Insurance	**Policyholder's Name**	**Relationship**
Secondary Insurance	**Policyholder's Name**	**Relationship**

ALL INSURANCE COPAYS ARE TO BE PAID AT TIME OF SERVICE.

All professional services rendered are charged to the patient. Our office will complete the necessary forms to help expedite insurance payments. However, the patient is responsible for all fees regardless of insurance coverage including denied or non-covered services by Medicare, Medicaid and Medicaid Managed Care Plans.

INSURANCE AUTHORIZATION AND ASSIGNMENT

Name of Policyholder _____

I hereby assign payment directly to Associates in Womens Health, L.L.C. any medical and/or surgical benefits for professional services rendered. I understand that I am financially responsible for my deductible, coinsurance, copayments, services received without prior authorization and any allowable charges by my insurance company/companies, Medicare and Medicaid. I also authorize the release of information to another physician, hospital or insurance company as may be necessary for further treatment or determination of benefits and payments.

Patient Signature **X**_____ Date _____

Personal Representative Signature **X**_____ Date _____

Relationship to Patient _____