Patient Information: Date: _____

Patient Name: _____ Age: _____ Date of Birth: _____

Billing Address: _____ City: _____ State: _____ Zip: _____

Physical Address: _____ City: _____ State: _____ Zip: _____

Primary Phone: _____ (home) (cell) Secondary Phone: _____

E-mail Address: _____ Social Security Number: _____

How did you hear about us? _____

Pharmacy Local: _____ Mail Order: _____

Emergency Contact:

Name: _____ Relationship: _____ Phone: _____

Responsible Party:

Name: _____ Relationship: _____ Date of Birth: _____ SS# _____

Mailing Address: _____

Insurance Information:

Primary Insurance: _____ Subscriber's name: _____

Subscriber's DOB: _____ Insurance ID#:_____ Group#: _____

Seconday Insurance: _____ Subscriber's name: _____

Subscriber's DOB: _____ Insurance ID#:_____ Group#: _____

Financial Responsibility and Assignment of Insurance Benefits:

I guarantee payment to Iredell Family Primary Care for Women and its affiliates of all charges for services provided to the patient. I understand I am personally responsible for all charges not covered by insurance. I authorize payment of surgical and medical benefits, which would otherwise be payable to me, to Iredell Primary Care for Women for services rendered. If covered by Medicare or Medicaid, I certify that the information provided by me in applying for payment under Titles V, XVIII, and/or XIC of the Social Security Act is correct.

Appointment Policy: I understand that I have a responsibility to keep the appointments that are scheduled for me. If for any reason I cannot make the appointment, I understand that I need to call in advance to cancel and reschedule. I understand that if I NO SHOW for 3 appointments, I may be discharged from this practice.

Signature of Patient or Authorized Person: _____ Date/Time: _____

Financial Guarantor (if different from above): _____ Date/Time: _____

If limited English proficient or visually impaired, we will offer an interpreter at no additional cost.