



PATIENT INFORMATION

Date: _____ MRN #: _____

Last Name: _____ First Name: _____

Date of Birth: _____ SSN # _____

Home Telephone: _____ Cell #: _____

Mailing Address: _____

City: _____ State: _____ Zip: _____

Employer: _____ Work # : _____

Emergency Contact Name & Number: _____

Referring Physician: _____

PRIMARY INSURANCE

Insurance Plan Name: _____

Subscriber's Name: _____ DOB: _____

Subscriber's Employer: _____

Insurance Policy ID #: _____ Policy Group #: _____

Relationship to Patient: _____

SECONDARY INSURANCE

Insurance Plan Name: _____

Subscriber's Name: _____ DOB: _____

Subscriber's Employer: _____

Insurance Policy ID #: _____ Policy Group #: _____

Relationship to Patient: _____

ASSIGNMENT OF BENEFITS

I hereby authorize the release of medical information to my insurance company(s), and assign benefits otherwise payable to Solis Women's Health and all of its subsidiaries. A copy of this is as valid as the original. ***I understand that payment is due at the time of service, and I am fully responsible for my charges.***

Revocation: I understand that this authorization may be revoked in writing at any time, except to the extent that action has been taken in reliance on this authorization for the purposes stated above.

I further release my physician from any liability arising from the release of information to the individual(s) agency designated herein.

SIGNATURE OF PATIENT

DATE