Wellesley Women's Care, P.C.

PPG____

Thank you for taking the time to complete this form. We ask that you complete this entire form once a year **or** when you have any *NEW* information.

PATIENT INFORMATION (Please print clearly)

Name ______________________________________ DOB____/____/____ SS#____/____/________

Street Address____________________________City/State/Zip______________________________

Home (_____)_______-_________Cell(_____)_______-_________Work(_____)_______-___________

Emergency Contact____________________________ _____________Day Phone(_____)_______-___________

Email (optional)________________________________

You are welcome to include your email address, although it is not intended to be a primary contact method for your physician and/or our office.

Primary Care Physician ________________________________Phone(_____)_______-___________

Are we able to leave a voice mail message at the numbers you have provided?	YES	NO
Do you want a chaperone present during your exams?	YES	NO

PRIMARY INSURANCE INFORMATION

Insurance Company / Address____

Policy / Certificate #____Group#______________________________

Policy Holder Name____________________________ _________Relationship to patient Self / Spouse / Parent / Partner

Policy Holder Employer____

Policy Holder SS# _______/_______/_________ DOB____/_____/_______

Policy Holders address (if different from patient)____

Secondary Insurance Information

Insurance Company / Address____

Policy / Certificate #____Group#______________________________

Policy Holder Name____________________________ _________Relationship to patient Self / Spouse / Parent / Partner

Policy Holder Employer____

Policy Holder SS# _______/_______/_________ DOB____/_____/_______

Policy Holders address (if different from patient)____

Insurance Authorization and Assignment **(ALL PATIENTS)**

I hereby authorize Wellesley Women's Care, P.C. to furnish information necessary to the above insurance carriers concerning my illnesses and treatments. I hereby assign WWC,P.C. all payments for medical services rendered with out a valid referral that may be required by my HMO, all services provided to me, if at the time of service my insurance carrier does not contract with WWC,P.C. and any amount not covered by my insurance.

Patient / Guardian Signature____**Date**________________

MEDICARE PATIENTS ONLY MEDICARE AUTHORIZATION AND PAYMENT REQUEST

I certify that the above information given by me in applying for under Title XVII of the Social Security Act is correct. I authorize Wellesley Women's Care, P.C. to release any medical information about me to the Social Security Administration or intermediaries or carriers needed for medical claims. I request that payment of authorized benefits be made on my behalf to WWC, P.C. I assign benefits payable to WWC, P.C. for the services rendered, to WWC, P.C.

Patient / Guardian Signature____**Date**________________