Women's Institute for Gynecology & Minimally Invasive Surgery, LLC

1600 Sixth Ave, Suite #117
York, PA 17403
(717) 840-9885 (717) 840-9313 Fax

Your Name_____________________________________ **Social Security** __________________________

Maiden/Other Name___________**Marital Status**_______**Age**_____**Date Of Birth**________________

Your Present Address____
(street) (city) (state) (zip code)

Home Phone #_______________**Work Phone #**_______________**Cell Phone #**___________________

Your Employer____

Your Occupation_________________________ **Circle One** **Full-time Part-time Self-Employed**

Husband's Name_______________**Husband's Soc. Sec. #**___________**Husband's Age**____________
Husband's Address (if different from above)____
Husband's Date Of Birth______________**Husband's Employer**_______________________________
Husband's Occupation_________________**Husband's Work Phone #**__________________________
Circle One **Full-time Part-time Self-Employed**

Name Of Family Doctor_________________**How were you referred to our Practice?**_____________
Emergency Contact (not husband)____________**Relationship**_______**Phone #**____________________

****This section must be completed in order for us to submit your claims to your insurance company:****

Primary Insurance
Policy Holder's Name_________________________
Name Of Ins. Co._____________________________
Subscriber's Birth Date________________________
Subscriber's SSN_____________________________
Subscriber's Employer_________________________

Secondary Insurance
Policy Holder's Name____________________
Name Of Ins. Co._________________________
Subscriber's Birth Date__________________
Subscriber's SSN_________________________
Subscriber's Employer___________________

Responsible Party Name (for billing purposes)_________________________**Relationship**____________
Responsible Party Address____
Responsible Party Home Phone #_______________**Responsible Party Work Phone #**_____________

PLEASE SHOW THE RECEPTIONIST YOUR INSURANCE CARD (S).

By my signature below, I authorize the release of any medical or other information deemed necessary by Women's Institute for Gynecology & Minimally Invasive Surgery, LLC including the transfer of all or a portion of any medical records to support medically necessary referrals to other health care providers.

By my signature below, I authorize payment of medical benefits to Women's Institute for Gynecology & Minimally Invasive Surgery, LLC.

By my signature below, I have read and understand the Financial Policy on thre reverse of this form.

Signature____ **Date**__________________________

****Please read Financial Policy on reverse side****
(Office will attach copy of Insurance Card)