

PATIENT INFORMATION

NAME: _____ AGE: _____ SSN: _____ - _____ - _____

STREET ADDRESS: _____ MAILING ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____ HOME PHONE: (_____) _____

CELL PHONE: (_____) _____ BIRTHDATE: ____ / ____ / ____ SINGLE ___ MARRIED ___ WIDOWED ___

EMPLOYER: _____ OCCUPATION: _____

ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

WORK PHONE: (_____) _____

STUDENT: Y ___ N ___ FULL-TIME: ___ PART-TIME ___ SCHOOL: _____

IF MINOR, PLEASE LIST PARENT OR GUARDIAN: _____

ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

HOME PHONE: (_____) _____ CELL PHONE: (_____) _____

SPOUSE/RELATIVE INFORMATION

SPOUSE: _____ BIRTHDATE: ____ / ____ / ____ OCCUPATION: _____

EMPLOYER: _____ WORK PHONE: (_____) _____

ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

NEAREST RELATIVE/FRIEND OTHER THAN SPOUSE: _____

RELATIONSHIP TO PATIENT: _____ PHONE NUMBER: (_____) _____

ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

INSURANCE INFORMATION

INSURANCE COMPANY: _____ **SUBSCRIBER NAME:** _____

BIRTHDATE: ____ / ____ / ____ SSN#: _____ - _____ - _____ I.D.# _____

EMPLOYER: _____ RELATIONSHIP TO PATIENT: _____

SECONDARY INSURANCE COMPANY: _____

SUBSCRIBER NAME: _____ **BIRTHDATE:** ____ / ____ / ____ **SSN#:** _____ - _____ - _____

I.D.#: _____ **EMPLOYER:** _____

ASSIGNMENT OF BENEFITS FOR SURGERY, PREGNANCY AND OFFICE PROCEDURES:

I assign all medical and/or surgical benefits to include major medical benefits to which I am entitled, including Medicare, Private Insurance and any other health plan to Southern Utah Women's Health Center, P.C. and/or Grant L. Carter, M.D., Craig D. Astle, M.D., Jeffrey G. Rogers, M.D. Tracy W. Winward, M.D., Joan V. Eggert, M.D., Brady N. Benham, M.D., Pamela Sorensen, PA-C, Michelle MacFarlane, M.P.A.-C. This assignment will remain in effect until revoked by myself in writing. A photo copy of this assignment is to be considered as valid as an original. I hereby agree to pay all fees for services rendered. I understand that I am financially responsible for all charges whether or not paid by said insurances. I hereby authorize said assignee to release all information necessary to process claims and secure payment.

SIGNED _____ **DATE:** _____