

**LEGAL**

**NAME:** \_\_\_\_\_ **AGE:** \_\_\_\_\_ **SSN:** \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_  
First M.I. Last

**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 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. 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:** \_\_\_\_\_