Girls to Women
HEALTH AND WELLNESS

PATIENT DEMOGRAPHIC and INSURANCE INFORMATION **DATE: ____/____/_____**

_____ _____ _____ _____
Last Name First Name (Nickname, if applies) Date of Birth

_____ _____ _____
Address City and State Zip

Home Phone: _____ **Patient** Cell: _____ **Patient** Email (optional): _____
(May we send our email newsletters? ___Yes ___No)

How were you referred to our practice? _____ Appointment O Rubin-Remer O Sugerman O Musacchio

PARENT(S)/GUARDIAN(S) INFORMATION

Name: _____ Relationship to Patient: _____ Address: _____City: _____State/Zip: _____

Home Phone (if different): _____ Cell Phone: _____ Work: _____ Email contact: _____
(May we send our email newsletters? ___Yes ___No)

Name: _____ Relationship to Patient: _____ Address: _____City: _____State/Zip: _____

Home Phone (if different): _____ Cell Phone: _____ Work: _____ Email contact: _____
(May we send our email newsletters? ___Yes ___No)

Please note any custody arrangements or guardianship: _____

OTHER EMERGENCY CONTACT: _____ Phone: _____ Relationship: _____

PHARMACY _____ _____ _____
Name (and cross streets if known) Pharmacy Phone (if known) Pharmacy Fax (if known)

INSURANCE INFORMATION

Subscriber Name: _____ DOB: _____ Relationship to patient: _____

Insurance Company: _____ Phone #: _____ Member ID: _____ Group#: _____

Address:_____City: _____ State: _____ Zip: _____

Effective date: _____ Copay: _____ Deductible: _____

Authorization for Release of Information to Insurance and Assignment of Insurance Benefits

I hereby authorize release of information to _____Insurance Company and assignment of insurance benefits to Girls to Women Health and Wellness, PA, Drs. Rubin-Remer, Sugerman, and Musacchio, as this information may be necessary for the completion of my medical claims. I understand I am financially responsible for all charges not covered by my insurance company.

_____ _____ _____/_____/_____
Patient Name (print) Patient Signature (adult patients only) Date

_____ _____ _____/_____/_____
Responsible Party (print) (if patient is a minor) Responsible Party Signature (if patient is a minor) Date