

Women's Healthcare of Southern Indiana, LLC
5300 State Road 64, Suite 103
Georgetown, IN 47122
Phone 812-923-6200 Fax 812-923-6204

You have an appointment with Dr. _____ On _____

Please complete this form and mail to our office at the above address BEFORE your appointment Date. PLEASE PRINT ENTIRE FORM. Thank You.

Patient Name _____ Referred By _____
Address _____ Soc. Sec # _____ / _____ / _____
City _____ St. _____ Zip _____ Birth Date _____
Employer _____ Hm. Phone _____ Wk Phone _____
Occupation _____

Spouse (Parent) _____ Date of Birth _____
Employer _____ Address _____
Hm Phone _____ Occupation _____
Soc. Sec. # _____

Name of nearest relative
not living with You _____ Relationship _____
Address _____ Hm. Phone _____
City _____ St _____ Zip _____

Please provide all pertinent information regarding your insurance coverage. If you have coverage by more than one company please supply information regarding both companies.

Insurance Co _____ Insurance Co _____
Address _____ Address _____
Insured Person _____ Insured Person _____
Policy Holder _____ Policy Holder _____
Patient is: __ Spouse __ Son __ Daughter __ Other Patient is: __ Spouse __ Son __ Daughter __ Other
Group # _____ Group # _____
Effective Date: _____ Effective Date: _____

ASSIGNMENT OF INSURANCE BENEFITS

I authorize direct payment of surgical/medical benefits to Women's Healthcare of Southern Indiana, LLC for service rendered by them in person or under their supervision. I understand that I am financially responsible for any balance not covered by my insurance.

AUTHORIZATION TO RELEASE INFORMATION

I hereby authorize Women's Healthcare of Southern Indiana LLC to release any medical or incidental information that may be necessary for either medical care or in processing applications for financial benefits.

REFERRALS

YOU ARE RESPONSIBLE FOR OBTAINING YOUR REFERRAL TO OUR OFFICE AND WILL BE RESPONSIBLE FOR ANY DENIED CHARGES WHEN THIS IS NOT OBTAINED.

A photocopy of these assignments shall be valid as the original.

Signature _____ Date _____ Patient
(Please Print) _____

