

1625 N. George Mason Drive
Suite 474
Arlington, VA 22205
(703) 528-6300



1875 Campus Commons Drive
Suite 110
Reston, VA 20191
(703) 437-8080

Year: _____

PATIENT INFORMATION

Account #: _____

Name First Middle Last			Date of Birth		Marital Status <input type="checkbox"/> S <input type="checkbox"/> M <input type="checkbox"/> D <input type="checkbox"/> W	
Home Address			Apt. No	City	State	Zip Code
Phone No. Cell		Phone No. Home		Phone No. Work		Preferred Method of Contact <input type="checkbox"/> Text <input type="checkbox"/> Email <input type="checkbox"/> Call
Email Address				Preferred Language		Race & Ethnicity
Employer			Employer Address			
Spouse (or Parent) Name			Spouse (or Parent) Phone No.		Emergency Contact and Phone No.	
Preferred Pharmacy Name, Address, and Phone No.					Mail Order Pharmacy	

NOTICE OF PRIVACY PRACTICES (HIPAA)

*** I have received and/or reviewed Healthcare for Women's Notice of Privacy Practices (HiPAA) today, I authorize this practice to call/leave messages regarding my medical appointments, test results, conditions, etc. at: Home _____ Work _____

Cell _____ Patient Signature _____

*** I authorize the following individual(s) to have access to my medical appointments, test results, conditions, etc.:

1. Name: _____ Phone: _____ 2. Name: _____ Phone: _____

PRIMARY INSURANCE

Insurance Company Name	ID or Policy Number	Group/Code	Date Effective
Subscriber's Name	Relationship to Patient	Subscriber's Social Security #	Subscriber's Date of Birth

SECONDARY INSURANCE

Insurance Company Name	ID or Policy Number	Group/Code	Date Effective
Subscriber's Name	Relationship to Patient	Subscriber's Social Security #	Subscriber's Date of Birth

PATIENT AUTHORIZATION

I certify that all of the above information is true and accurate. I hereby authorize Healthcare for Women to apply for benefits on my behalf for services rendered with my Insurance company using the information I have provided. I further authorize the release of any necessary information, including medical information for any related claim, to the above named insurance company. I permit a copy of this authorization to be used in place of the original. This authorization may be revoked by either me or the above named Insurance company, at any time in writing.

Date _____ Signature _____