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: ____________________

Account #: ________________________________

PATIENT INFORMATION

Name First Middle Last	Date of Birth	Marital Status ❑ S ❑ M ❑ D ❑ W
Home Address / Apt. No / City / State		Zip Code
Phone No. Cell / Phone No. Home	Phone No. Work	Preferred Method of Contact ❑ Text ❑ Email ❑ 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 ____