ADVANCED WOMEN'S HEALTH SPECIALISTS
44344 Dequindre Rd., Suite 570
Sterling Heights, MI 48314
(586) 262-5060

PATIENT INFORMATION

Name ______________________ Social Security # ______________

Address ______________________ City ______________ State ______ Zip ______

Home Telephone # ______________________ Cell # ______________

Date of Birth: ______________ Marital Status: M S D W (circle one)

Email address: ______________________

Emergency Contact: ______________ Relationship to you ______ Phone ______________

PREFERRED PHARMACY NUMBER: ______________________

Employed by: ______________________

Occupation: ______________________ Work phone # ______________

REFERRAL INFORMATION

Whom may we thank for referring us? ______________________

Primary Care Physician ______________________ Phone # ______________

INSURANCE INFORMATION

Primary Insurance ______________________ Secondary Insurance ______________

Contract Number ______________________ Group Number ______________

**If your spouse is the Subscriber to the insurance, please give the following information:

Spouse Name ______________________ DOB ______ Soc. Sec. # ______________

ASSIGNMENT & RELEASE

I, the undersigned certify that I or my dependant, have insurance coverage with the above named insurance(s). I assign directly to Advanced Women's Health Specialists all insurance benefits. If any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the physician to release all information necessary to secure payment of benefits. I authorize the use of this signature on all insurance submissions.

______________________ ______________________ ______________
Responsible Party Signature Relationship to patient Date