

ADVANCED WOMEN'S HEALTH SPECIALISTS
44344 Dequindre Rd., Suite 460
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