PATIENT INFORMATION FORM

Joan L. Bergstrom, M.D., F.A.C.O.G.
Dawnette Peppler, M.D., F.A.C.O.G.

Your Physician's Name ______________________________

PATIENTS NAME____
(last) (first) (mi) (maiden)

ADDRESS____
(street) city) (state) (zip)

PHONE #'S____
(home) (cell) (work)

SEX M/F_______DATE OF BIRTH___________________SS#______________________DRIVERS LICENSE#_____________________

MARITAL STATUS: SINGLE_____MARRIED_____DIVORCED_____WIDOWED_____OTHER_____

PATIENT'S EMPLOYER____

EMPLOYERS ADDRESS____

SPOUSE'S/GUARDIAN'S INFORMATION

NAME____WORK PHONE__________________CELL_________________________

DATE OF BIRTH_____________________________SS#____

EMPLOYER____
(name) (address)

EMERGENCY CONTACT____
(name) (relationship) (phone)

PRIMARY INSURANCE

INSURANCE COMPANY____PHONE #_________________________________

NAME OF INSURED____DOB__________________________________

SELF_____ SPOUSE_____ PARENT_____ OTHER_____ COPAY AMOUNT____

INSURED'S EMPLOYER____

CLAIM'S ADDRESS____

ID#_______________________GROUP #____________________INSURED SS#____

SECONDARY INSURANCE

INSURANCE COMPANY____PHONE #_________________________________

NAME OF INSURED____DOB__________________________________

SELF_____ SPOUSE_____ PARENT_____ OTHER_____ COPAY AMOUNT____

INSURED'S EMPLOYER____

CLAIM'S ADDRESS____

ID#_______________________GROUP #____________________INSURED SS#____

INSURANCE AUTHORIZATION AND ASSIGNMENT

I authorize WHS to release to my insurance carrier and/or their agents any information necessary to determine benefits payable for related services. I authorize the payment of medical benefits to WHS. I understand that I am ultimately responsible for all services whether covered by insurance or not. I also authorize my physician based on his/her discretion to access my chart for utilization management review.

DATE_______________________SIGNATURE____

1001 Waldrop Drive, Suite 505, Arlington, Texas 76012
Phone: 817 277 9415 Fax: 817 277 0360
www.womenshealthservices.com