FAYETTEVILLE Woman's CARE, P.A.

NEW PATIENT INFORMATION RECORD (PLEASE PRINT OR WRITE LEGIBLY)

PATIENT'S NAME	RACE	MARITAL STATUS S M W DIV SEP	DATE OF BIRTH	AGE	SOCIAL SECURITY NO.
STREET ADDRESS		PERMANENT TEMPORARY			HOME PHONE NO.
P.O. BOX		CITY		STATE	ZIP CODE
PATIENT'S EMPLOYER	OCCUPATION (INDICATE IF STUDENT)		HOW LONG EMPLOYED	BUSINESS PHONE NO.	
EMPLOYER'S STREET ADDRESS		CITY		STATE	ZIP CODE
IN CASE OF EMERGENCY CONTACT:		RELATIONSHIP	PHONE NO.		PATIENT'S DRIVER'S LIC. NO.
SPOUSE'S NAME			DOB		SOCIAL SECURITY NO.
SPOUSE'S EMPLOYER	RANK/GRADE	OCCUPATION (INDICATE IF STUDENT)	HOW LONG EMPLOYED		BUSINESS PHONE NO.
EMPLOYER'S STREET ADDRESS		CITY		STATE	ZIP CODE
WHOM MAY WE THANK FOR REFERRING YOU TO THIS PRACTICE?			PATIENT'S HEIGHT		WEIGHT

IF THE PATIENT IS A MINOR OR STUDENT

MOTHER'S NAME	STREET ADDRESS, CITY, STATE, AND ZIP CODE	DOB	HOME PHONE NO.
MOTHER'S EMPLOYER	OCCUPATION	HOW LONG EMPLOYED	BUSINESS PHONE NO.
EMPLOYER'S STREET ADDRESS	CITY, STATE AND ZIP CODE	SOCIAL SECURITY NUMBER	
FATHER'S NAME	STREET ADDRESS, CITY, STATE, AND ZIP CODE	DOB	HOME PHONE NO.
FATHER'S EMPLOYER	OCCUPATION	HOW LONG EMPLOYED	BUSINESS PHONE NO.
EMPLOYER'S STREET ADDRESS	CITY, STATE AND ZIP CODE	SOCIAL SECURITY NO.	

INSURANCE INFORMATION

PERSON RESPONSIBLE FOR PAYMENT, IF NOT ABOVE	STREET ADDRESS, CITY, STATE, AND ZIP CODE		HOME PHONE NO.
COMPANY NAME & ADDRESS	NAME OF POLICY HOLDER	POLICY NO.	GROUP NO.
COMPANY NAME & ADDRESS	NAME OF POLICY HOLDER	POLICY NO.	GROUP NO.
COMPANY NAME & ADDRESS	NAME OF POLICY HOLDER	POLICY NO.	GROUP NO.

MEDICARE NO.	MEDICAID NO.	PROGRAM NO.	COUNTY NO.	ACCOUNT NO.

Because of the high cost of billing, we ask that you be prepared to pay for your visit before leaving our office.
Please circle method of payment: MasterCard Visa Discover Check Cash

Authorization: I hereby authorize Fayetteville Woman's Care to furnish information to the insurance carriers concerning this illness/accident and I hereby irrevocably assign to the doctor all payments for medical services rendered. I understand that I am financially responsible for all charges whether or not covered by insurance. If this account is assigned to a collection agency or an attorney, I will be responsible for a 25% administration fee.

Responsible Party Signature Date