Please **COMPLETELY** fill out all applicable information & return this form to the front desk

Patient Demographics

Patient Name: _____ DOB: _____
Address: _____ SS#:_____
City: _____ Race: _____ Ethnicity: _____
State: _____ Zip Code: _____ Language: _____
Home: _____ Marital Status: _____
Work: _____ Spouses Name: _____
Cell: _____ May we contact you about your confidential health
E-Mail Address: _____ Information by e-mail? Yes No

I hereby authorize Physicians & Midwives to obtain/download my medical history from Pharmacies and/or Pharmacy Benefit Managers. This authorization will allow my physician to check drug to drug interactions for any new prescriptions he/she may prescribe and to facilitate electronic pharmacy prescriptions. I understand this authorization will remain in effect until revoked by me in writing. Initial: _____ Date: _____

Preferred Pharmacy Name & Location: _____

Contact Preference: (Please Circle) Home Work Mobile Phone Mail Portal

Patient Insurance Information

Primary Insurance

Insurance Name: _____
Subscriber's Name: _____
Subscriber's Relation: _____
Subscriber's DOB: _____
Subscriber's SS#:_____
Subscriber's Address: _____
Subscriber's Employer: _____

Secondary Insurance (if Medicare is Primary)

Secondary Insurance Name: _____
Subscriber's Name: _____
Subscriber's Relation: _____
Subscriber's DOB: _____
Subscriber's SS#: _____
Subscriber's Address: _____

Emergency Contact & Consent to Share Information

Emergency Contact: _____ Relation: _____ Phone#:_____

Is there anyone you give permission to share your private health information with: If so, please list below:
Name: _____ Relation: _____ Phone#:_____
Name: _____ Relation: _____ Phone#:_____

AUTHORIZATION

I hereby authorize the release of all medical information necessary for the processing of insurance claims. I also authorize my insurance company to make payments directly to "The Physician and Midwife Collaborative Practice".
I understand I am responsible for payment denied by my insurance due to lack of referral and/or inaccurate insurance information.
I understand that I am responsible for obtaining referrals prior to my appointment.
I understand that I am responsible for the payment of any portion of my bill not paid by my insurance company. I also understand that if my account is turned over for collection, I will be charged a $25 late fee. This fee is non-negotiable. **(Accounts are not turned over for collection without notification to the patients or clients).** Physicians and Midwives will send two statements, prior to turning an account over to collections. **I understand that if my account is turned over for collections, I will not be able to make any future appointments until the debt is paid in full".**

Patient Signature: _____ Date: _____

Patient Signature: _____ Date: _____

Revised 10/22/2018