

**ST. LUKE'S CENTER FOR ADVANCED GYNECOLOGIC CARE
PATIENT CARE INFORMATION**

PATIENT NAME: _____
(Last) (First) (Middle)

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

HOME PHONE #: _____

E-MAIL: _____ (Can we contact you by email?) Yes No

EMPLOYER: _____

WORK PHONE #: _____ CELL PHONE #: _____

DATE OF BIRTH: _____ SOCIAL SECURITY NUMBER: _____

MARITAL STATUS: Married Single Divorce Widow
(Please circle one)

PRIMARY CARE PHYSICIAN: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

PHONE NUMBER: _____

MEDICAL HEALTH INSURANCE

PRIMARY INSURANCE COMPANY: _____

SUBSCRIBER'S NAME: _____

SUBSCRIBER'S DOB: _____ RELATION TO PT: _____

SOCIAL SECURITY NUMBER: _____

ID#: _____ GROUP#: _____

EMPLOYER: _____ EMPLOYER PHONE #: _____

SECONDARY INSURANCE: _____

SUBSCRIBER'S NAME: _____

SUBSCRIBER'S DOB: _____ RELATION TO PT: _____

SOCIAL SECURITY NUMBER: _____

GROUP#: _____ ID#: _____

EMPLOYER: _____ EMPLOYER PHONE #: _____

INSURANCE AUTHORIZATION AND ASSIGNMENT

I request that payment of authorized insurance/ Medicare benefits be made on my behalf of the provider of service(s) for any services furnished me. I authorize any holder of medical information about me to release to Health Care Financing Administration and its' agent and information needed to determine these benefits of the benefits payable to related services. I hereby authorize payments directly to St. Luke's Center for Advanced Gynecologic Care, the provider of the service(s) for the medical benefits. I hereby authorize St. Luke's Center for Advanced Gynecologic Care, the provider of the service(s) to release any medical information necessary to process my claim. I hereby authorize the photocopies of this form to be as valid as the original.

PATIENT'S SIGNATURE: _____ DATE: _____