*Perfectly Female Women's Health Care, P.C.*

# Patient Information Sheet

Name (Last): _____(First):_____(MI):_____

Soc Sec #:_____ Marital Status: Single Married Divorced (please circle one) Widowed Separated

Home (_____)-_____.

Date of Birth: _____ Age: _____

Work (_____)-_____.

Address: _____

Cell (_____)-_____.

City: _____State: _____Zip:_____

Email _____

**********

Guarantors Name: _____
(person the insurance is carried by)

Relationship to Guarantor: Self Spouse Child Other
(please circle one)

Insurance Company: _____

Guarantor Info (if Guarantor is not = SELF)

Social Security #: ……..……

Employer:……..……..……

***Date of Birth***: ……..……..……..…

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**Emergency Contact:** _____ **Phone (_____)-_____.**

Person(s) we may discuss your Medical Information with:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

**********

Employer: _____ Occupation: _____

Primary Care MD: _____ Phone (_____)-_____.

Referred By: _____

**ALL OF THE ABOVE ARE REQUIRED FIELDS**

This office will file your insurance claims; however, the patient is responsible for all fees, regardless of insurance coverage. If you are a self pay patient, you will be responsible for the office visit today and the lab will bill you for any labs that are done**. If your co pay is not paid when services are rendered, an additional charge of $10.00 will be added to your statement to cover our cost of sending a bill.** **This office orders lab tests according to medical necessity.** Your insurance company will determine what is paid for. All lab work will be billed to your insurance company by the laboratory**. If there are any questions regarding bills received from a lab, please contact the lab directly. I understand that I am financially responsible for all charges for services to me, including any balance remaining after possible insurance payments.** I authorize payment of medical benefits to Perfectly Female Women's Health Care, P.C. for services provided. I authorize the release of medical information needed to process any insurance claim. I acknowledge the Virginia Code: Section 32.1-45.1, which states that should an exposure of my blood occur to a healthcare worker, I may be tested for Hepatitis B and C, and HIV. I acknowledge that Perfectly Female Women's Health Care utilizes the Prescription Monitoring Program for the health and well-being of our patients.

SIGNED_____DATE_____