



About You

Name _____ Today's Date _____
Last First Middle Initial
 Date of Birth _____ Age _____ Social Security # _____
 Mailing Address _____
Street City State Zip
 Phone (home) _____ Phone (work) _____ Phone (other) _____
 Email Address _____
 Employer _____ How Long? _____
 Employer Address _____
Street City State Zip
 Occupation _____
 Marital Status Single Married Divorced Widowed
 Spouse's Name _____ Do You Have Children? _____ How Many? _____
 Primary Care Physician _____ Physician Phone _____

In Case of Emergency

Who Should We Contact? _____ Relationship _____
 Phone (home) _____ Phone (work) _____ Phone (other) _____

Primary Insurance

Company Name _____ Phone _____
 Address _____
Street City State Zip
Policy Holder or Subscriber _____ Relationship to Patient _____
 Date of Birth _____ Social Security # _____
 Employer _____
 Employer Address _____ Employer Phone _____
Street City State Zip

Secondary Insurance

Company Name _____ Phone _____
 Address _____
Street City State Zip
 Policy Holder or Subscriber _____ Relationship to Patient _____
 Date of Birth _____ Social Security # _____

Pharmacy Information

Pharmacy Name _____ Phone _____
 Pharmacy Address / Cross Streets _____

Do You Have An Advance Healthcare Directive? Yes No **If Yes, Please Bring A Copy To The Office**
 How Did You Hear About Our Office? _____

Women At Bayview will assist its patients in making every effort to collect payments from the patient's or guarantor's insurance company through **courtesy** filing of insurance claims and other required documentation. Since most carriers have time limits for filing correct information, it is imperative that we receive complete and correct insurance information. Though assistance will be provided, it is the patient's responsibility to make sure his/her insurance carrier pays his/her claim. Patients or their guarantors are responsible for payment in full of their financial obligations whether or not their insurer makes a payment.

Signature _____ Date _____