Patient Information Sheet

Women's Health Alliance, P.A.
pka
Wilkerson Obstetrics & Gynecology
Raleigh, N. C. 27607

Office Use Only

Patient # _____

Doctor # _____

Today's Date _____

Please Print

Name: _____ Age: _____ Date of Birth ___/___/___
First Middle Maiden Last M D YEAR

☐ Child ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widow

Street Address: (not a P.O. Box) _____
Street Apt#

City: _____ State: _____ Zip Code: _____ Email: _____

Telephone: _____ Cell Phone: _____

Employer's Name & Address: _____ Telephone: _____

SS# _____ Type of Work: _____

Emergency Contact Name _____ Phone _____ Relationship _____

Pharmacy Name: _____ Address _____ Phone: _____

Spouse's/Guardian/Parent's Name: _____

Spouse's Employer: _____ Spouse's Work Phone: _____

Spouse's SS #: _____ Date of Birth _____

Who referred you to this office? (Name and address if doctor) _____

Payment is due at time service is rendered:

I plan to make payment of my medical expenses as follows: (check one or more)

☐ Cash / Check ☐ Medicare ☐ Master Card / Visa

Please list your Insurance Carrier(s). We file insurance for State Health Plan, Blue Cross and Blue Shield (BCBS), Medicare, and various HMO insurance plans. We do not file for any other insurance companies except for obstetrical and surgical patients. If you have other insurance, you may file yourself with the receipt given to you when you check out. Just attach this receipt to your insurance form and file.

Primary Insurance: _____ Cert#: _____ Policy #: _____

Policyholder's Name: _____ Relationship to Patient: _____

Secondary Insurance _____ Cert#: _____ Policy #: _____

Policyholder's Name: _____ Relationship to Patient: _____

Financial Agreement and Authorization for Treatment:

I authorize treatment of the person named above and agree to pay all fees and charges for such treatment. I agree to pay all charges promptly upon presentment thereof.
It is agreed that payments will not be delayed or withheld because of insurance coverage or the pendency of claims theron, and all proceeds of insurance are assigned to this office where applicable, but without their assuming responsibility for the collection thereof.
Insurance payments are based on what insurance companies consider usual and customary. Oftentimes insurance payments are not 100% of fees charged. I understand that I am responsible for any copays, co-insurance and / or deductibles.
I authorize the release of any medical information necessary to process insurance claims.

Signature: _____ Date: _____

PATIENT ACKNOWLEDGMENT AND CONSENT

For New Patients Only

I have been given a copy of Women's Health Alliance, PA p.k.a. Wilkerson OBGYN Notice of Privacy Practices version effective September 23, 2013. I consent to the uses and disclosures of my health information as outlined in the Notice.

_____ _____

Signature of Patient or Representative ***Date***

_____

Print Name

_____

Relationship of Representative to Patient

Please describe the Representative's authority to act on behalf of Patient: _____

_____

FOR Women's Health Alliance, PA p.k.a. Wilkerson OBGYN USE ONLY

If acknowledgment of receipt of the Notice of Privacy Practices is not obtained from the patient or the patient's representative, please explain your efforts to obtain acknowledgment and the reason you could not obtain it:

_____

_____

_____

_____