



University Women's HealthCare
 401 E. Chestnut Street, Suite 410
 Louisville, KY 40202
 502-271-5999

You have an appointment with Dr. _____ at _____ on ____/____/____

PLEASE PRINT ENTIRE FORM:

Patient Name: _____ Referred By: _____
 Address: _____ Soc. Sec. #: ____/____/____
 City: _____ State: _____ Zip: _____ Birth Date: ____/____/____
 Phone #: _____ Work #: _____ Employer: _____
 Cell #: _____ Email: _____ Occupation: _____

Spouse/Parent: _____ Soc. Sec. #: ____/____/____
 Address: _____ Birth Date: ____/____/____
 City: _____ State: _____ Zip: _____ Occupation: _____
 Phone #: _____ Work #: _____ Employer: _____
 Cell #: _____ Email: _____ Address: _____

Name of nearest relative not living with you: _____ Relationship: _____
 _____ Phone #: _____
 Address: _____ Work #: _____
 City: _____ State: _____ Zip: _____ Cell #: _____

AUTHORIZATION TO RELEASE INFORMATION: I HEREBY AUTHORIZE University Women's Health Care to release any medical or incidental information that may be necessary for either medical care or in processing applications for financial benefit.

REFERRALS: You are responsible for obtaining your referral to our office and will be responsible for any denied charges when this is not obtained.

Primary Insurance: _____ Secondary Insurance: _____
 Address: _____ Address: _____
 Insured Person: _____ Insured Person: _____
 Policy Holder: _____ Policy Holder: _____
 Group #: _____ Certificate #: _____ Group #: _____ Certificate #: _____
 Effective Date: _____ Effective Date: _____

Patient is: Self Spouse Son Daughter Other

ASSIGNMENT OF INSURANCE BENEFITS: I HEREBY AUTHORIZE direct payment of surgical/medical benefits to University Women's Health Care for services rendered by them in person or under their supervision. I understand that I am financially responsible for any balance not covered by my insurance.

PATIENT NAME (Print): _____ Date: _____
 PATIENT (GUARDIAN) SIGNATURE: _____ Date: _____

****A photocopy of these assignments shall be valid as the original.**