Please fill out all applicable information, including health insurance information.

PLEASE PRINT CLEARLY

Name: ____

Address:____

City: ____

State: ______________________ Zip Code: ________________

Home #: ____

Work #: ____

Cell #: ____

Email address: ____________________________________

Marital Status: SINGLE___ MARRIED___WIDOWED___SEPARATED___DIVORCED___

Who referred you to BAM? __________________________________

Date of Birth:______________________________________

Social Security#:____________________________________

Driver License#:____________________________________

Race: _______________ Religion: ________________

Employer:____

Employer Address:___________________________________

____

Spouse's Name:______________________________________

Spouse's Phone#:____________________________________

May we contact you about your confidential health information by email: YES NO

Is it OK to leave a voice message on(Please circle all that apply): HOME WORK CELL

Preferred Pharmacy#1:_______________________________

Alternate Pharmacy#2:_______________________________

PATIENT INSURANCE INFORMATION

Primary Insurance:__________________________________

ID#:____

GROUP#:____

Claims Address:____________________________________

____

Subscriber's Name:__________________________________

Subscriber's DOB:___________________________________

Subscriber's Employer:_______________________________

Subscriber's Daytime#:_______________________________

Relationship to subscriber: SELF PARENT SPOUSE/DOMESTIC PARTNER

Secondary Insurance:_________________________________

ID#:____

Group#: ____

Claims Address:____________________________________

____

Subscriber's Name:__________________________________

Subscriber's DOB:___________________________________

Subscriber's Employer:_______________________________

Subscriber's Daytime#:_______________________________

Relationship to subscriber: SELF PARENT SPOUSE/DOMESTIC PARTNER

EMERGENCY CONTACT & CONSENT TO SHARE HEALTH INFORMATION

Emergency Contact: ______________________________ Relationship:_____________________________

Phone#:____

Is there anyone you want to allow your private health information to be shared? If so, please list below:

Name: ___________________________ Relationship: ______________________ Phone#: ______________________

Name: ___________________________ Relationship: ______________________ Phone#: ______________________

AUTHORIZATION

I hereby authorize the release of all medical information necessary for the processing of insurance claims. I also authorize my insurance company to make payments directly to "Bay Area Maternity & Women's Health".
I understand I am responsible for payment denied by my insurance due to lack of referral and/or inaccurate insurance information.
I understand that I am responsible for obtaining referrals prior to my appointment if required.
I understand that I am responsible for the payment of any portion of my bill not paid by my insurance company.
I may request documentation for a nominal fee of **$25.00**
I agree that I will be responsible for a **$40.00** fee for any appointment cancellation that is provided with less than 24 hours notice.
I also understand that if my account is turned over to a collection agency, a **$25.00** fee will be assessed to my account. We regret that this fee cannot be waived.
(Delinquent accounts will not be turned over for 'Collection' without providing prior notification to the patient or client).
"I understand that if my account is turned over for collections, I will not be able to make any future appointments until the debt is paid in full".

Patient Signature: ____ Date: ______________________

Parent/Legal Guardian Signature (If patient is a minor): __________________________ Date: ______________________