Barton
Women's Health

PATIENT INFORMATION

Patient ID #: _____ Sex [ ] Male [ ] Female

Name: _____ Social Security #: _____ DOB: _____

Mailing Address: _____ Marital Status: [ ] Married [ ] Single [ ] Divorced [ ] Other

Street Address: _____ Email Address: _____

City, State, ZIP: _____ Primary: [ ]Home [ ]Work [ ]Cell: _____

Secondary: [ ] Home [ ] Work [ ] Cell: _____

Primary Care Physician: _____ Phone Number: _____

Ethnicity: Hispanic □ Non-Hispanic □ Refused □ Race: _____ Religion: _____

PATIENT EMPLOYMENT

[ ] Employed [ ] Retired [ ] Unemployed [ ] Self

Employer: _____

Job Title: _____

Phone: _____

PERSONAL / EMERGENCY CONTACTS

Name Relationship Phone

_____

_____

_____

GUARANTOR/RESPONSIBLE BILLING PARTY

[ ] Same as Patient

Name: _____

Address: _____

City, State, ZIP: _____

Phone: _____

RESPONSIBLE BILLING PARTY EMPLOYMENT

Employer: _____

Work Phone: _____

Social Security #: _____

Date of Birth: _____

PRIMARY INSURANCE Subscriber: [ ] Patient [ ] Responsible Billing Party [ ] Other

Subscriber Name: _____ Relationship to Patient: _____

Subscriber DOB: _____ Subscriber Social Security #: _____

Insurance Co.: _____ Insured ID: _____ Group #: _____

SECONDARY INSURANCE Subscriber: [ ] Patient [ ] Responsible Billing Party [ ] Other

Subscriber Name: _____ Relationship to Patient: _____

Subscriber DOB: _____ Subscriber Social Security #: _____

Insurance Co.: _____ Insured ID: _____ Group #: _____

ASSIGNMENT OF INSURANCE BENEFITS AND RELEASE OF MEDICAL INFORMATION:
I GIVE MY CONSENT FOR TREATMENT.

I herby authorize the release of any appropriate medical information to my insurance company; I assign all medical and/or surgical benefits, including major medical benefits to which I am entitled, including Medicare, private insurance and other health plans. This assignment will remain in effect until revoked by me in writing.

Signature: _____ **Date:** _____

We make every reasonable effort to obtain pre-approval, prior authorization and referral information. Your co-payment, co-insurance and/or deductible are due in full at the time of service. We will bill your insurance as a courtesy to you. On denied worker compensation claims, the patient's private/group health insurance may be billed. Ultimate financial responsibility remains with the patient and if the insurance company or worker compensation carrier denies payment, the bill is your responsibility. If you are unsure of any of these issues, please ask the staff before you see the physician.