PATIENT INFORMATION

DATE

PATIENT NAME:	MARTIAL STATUS: S M W D* SEP*	DATE OF BIRTH:	AGE:	SOCIAL SECURITY NO.
STREET ADDRESS:	APT# / CITY AND STATE	ZIP CODE	HOME PHONE:	
MAILING ADRESS	APT# / CITY AND STATE	ZIP CODE	CELL PHONE:	
PATIENT'S EMPLOYER	OCCUPATION (INDICATE IF STUDENT)	HOW LONG EMPLOYED	BUSINESS NO. EXT.	
EMPLOYER'S STREET ADDRESS	CITY AND STATE	ZIP CODE		
DRUG ALLERGIES	DRIVER'S LIC. No.			
SPOUSE'S/PARTNER'S NAME	SPOUSE'S/PARTNER'S DATE OF BIRTH	SPOUSE'S/PARTNER'S SOCIAL SECURTITY NO.		
SPOUSE'S/PARTNER'S EMPLOYER	OCCUPATION (INDICATE IF STUDENT)	HOW LONG EMPLOYED?	BUSINESS PHONE NO. EXT.	
EMPLOYER'S STREET ADDRESS	CITY AND STATE	ZIP CODE		
*HUSBAND'S STREET ADDRESS, IF DIVORCE OR SEPERATED:	CITY AND STATE	ZIP CODE	HOME PHONE NO:	
EMERGENCY CONTACT W/ RELATIONSHIP:	STREET ADDRESS	CITY AND STATE	ZIP CODE	HOME PHONE NO.
EMERGENCY CONTACT W/ RELATIONSHIP:	STREET ADDRESS	CITY AND STATE	ZIP CODE	HOME PHONE NO.

IF THE PATIENT IS A MINOR OR STUDENT

MOTHER'S NAME	STREET ADDRESS, CITY, STATE, AND ZIP CODE	HOME PHONE NO.	
MOTHER'S EMPLOYER	OCCUPATION	HOW LONG EMPLOYED?	BUSINESS NO.
EMPLOYER'S STREET ADDRESS	CITY AND STATE	ZIP CODE	
FATHER'S NAME	STREET ADDRESS, CITY, STATE, AND ZIP CODE	HOME PHONE NO.	
FATHER'S EMPLOYER	OCCUPATION	HOW LONG EMPLOYED?	BUSINESS NO.
EMPLOYER'S STREET ADDRESS	CITY AND STATE	ZIP CODE	

INSURANCE INFORMATION

1	NAME OF INSURANCE COMPANY	POLICY NO.	GROUP NO.
2	NAME OF INSURANCE COMPANY	POLICY NO.	GROUP NO.

EMAIL ADDRESS:_____ **REFERRING/PRIMARY MD:** _____

With regard to medical care and services provided or to be provided, IT IS AGREED, that the ATTENDING PHYSICIAN will provide medical care and services to the patient, to the best of his/her skills and knowledge, which in light of circumstances is possible and practical. The PATIENT will cooperate fully with the ATTENDING PHYSICIAN by obtaining such medication as are prescribed, by following the instructions of the ATTENDING PHYSICIAN, by adhering to such treatment or regimen or course of actions as may be set forth, for obtaining all necessary referrals or authorizations, and by paying all fees and charges in full as billed or as provided by prior special arrangements. It is agreed that: Because of differences in human constitution and response, it is in no way possible to warrant the outcome of such medical care and services. **By signing this consent form, you are agreeing that Camellia Women's Health can request and use your prescription medication history from other healthcare providers and/or third party pharmacy benefit payors for treatment purposes.** **Initials:** _____

I hereby authorize payment of insurance benefits available for medical/surgical services: Camellia Women's Health. I authorize the release of any medical or other information necessary to process insurance claims.

Dated:_____ **Patient:** _____

If the patient is a minor or incompetent, the parent or guardian should sign here, and in addition the minor should sign above, if possible.

Dated:_____ **Parent or Guardian:** _____

Dated:_____ **Parent or Guardian:** _____