

Salem Women's Clinic, Inc.

PATIENT INFORMATION RECORD (Please print)

Last Name: _____ First: _____ Middle Initial: _____

Mailing Address: _____
City State Zip

Physical Address: _____
City State Zip

Home Phone #: _____ Work Phone #: _____ Cell Phone #: _____

DOB: _____ Social Security #: _____ e-mail: _____

Marital Status: Single Married Widowed Separated Divorced Driver's License #: _____

Primary Care Physician: _____ Phone #: _____

Who Referred You to our Practice? _____

Employer Name: _____ Phone #: _____

Employer Address: _____
City State Zip

Spouse's Name: _____ Phone #: _____

Spouse's Employer: _____ Phone #: _____

In case of emergency contact: (name): _____ Phone #: _____

Nearest friend or relative not residing with you: _____

Relationship to Patient: _____ Phone #: _____

INSURANCE BILLING INFORMATION:

PRIMARY INS	EFFECTIVE DATE	SECONDARY INS	EFFECTIVE DATE
CLAIMS ADDRESS	PHONE #	CLAIMS ADDRESS	PHONE #
POLICY or ID # LOCAL	GROUP NUMBERS/UNION AND	POLICY or ID # LOCAL	GROUP NUMBERS/UNION AND
SUBSCRIBER NAME	RELATIONSHIP TO PT	SUBSCRIBER NAME	RELATIONSHIP TO PT
Subscriber Address	Subscribers DOB:	Subscriber Address	Subscribers DOB:
EMPLOYER	PHONE #	EMPLOYER	PHONE #

IS PATIENT A MINOR? _____ IF YES, Responsible Persons Name: (Please print) _____

Relationship to patient: _____ PH#: _____

I hereby authorize the Salem Women's Clinic to speak with the above name person regarding my account.

SIGN: _____ Date: _____

I consent to treatment necessary for the care of the above named patient or myself. I authorize the release of all medical records/information to the referring, referred, and/or family physician. I authorize the health care providers of Salem Women's Clinic, Inc. (SWC) to release my medical information that is needed to determine insurance benefits or benefits payable to the Health Care Finance Administration and its agents. I hereby assign to the SWC, all monies to be paid by said insurance company for services provided by SWC, but not to exceed my indebtedness to said clinic.

Print Patient's Name _____ Responsible Party Signature _____ Date _____

Account #: _____ Provider: _____