**Southwest Women's Healthcare**
**Patient Information**

**Pharmacy** _____

Family Doctor _____ (Maiden Name)_____

Name: (First) _____ (MI) _____ (Last) _____

Date of Birth: _____ Age: _____ Sex: M - F Marital Status: S – M – W – D

Address: (Street) _____ City: _____

State: _____ Zip Code: _____ Social Security: _____

Phone #: _____ Cell Phone # _____

**Insurance Information – Primary**

Insurance Co: _____ Phone #: _____

Group #: _____ Certificate or I.D. #: _____

Insured's Name: _____ Relationship to Patient: Self -Spouse- Dependent

Insured's Employer: _____ Phone #: _____

Insured's Social Security #: _____ Date of Birth: _____ Sex: M – F

**Insurance Information – Secondary**

Insurance Co: _____ Phone #: _____

Group #: _____ Certificate or I.D. #: _____

Insured's Name: _____ Relationship to Patient: Self -Spouse- Dependent

Insured's Employer: _____ Phone #: _____

Insured's Social Security #: _____ Date of Birth: _____ Sex: M - F

**Friend or Relative not living with you:** _____ **Phone #:** _____

**I herby assign, transfer, and set over to Southwest Women's Healthcare all of my rights, title, and interest to my medical reimbursement benefit under my insurance policy: I authorize the release of any medical information needed to determine these benefits. This authorization shall remain valid until written notice is given by me revoking said authorization.** *I understand that I am financially responsible for all charges whether* ***or*** *not they are covered by insurance. Specifically, I understand and agree that I am personally responsible for payment of co-pays, deductibles, and non-covered services rendered to me by SWWHI.*

Patient's Signature: _____ Date: _____

Witnessed by: _____ Date: _____

***Continue***

**ignature** _____

I have reviewed this consent form and give my permission to **Southwest Women's Healthcare, Inc** to use and disclosure my health information in accordance with it.

_____
Name of Patient (Print or Type)

_____
Signature of Patient

_____
Date

_____
Signature of Patient Representative

_____
Relationship of Patient Representative to Patient