

Women's Health Associates, P.C.

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Verify Date: _____ Int: _____
Verify Date: _____ Int: _____
Verify Date: _____ Int: _____

Patient Account # _____
Verify Date: _____ Int: _____
Verify Date: _____ Int: _____
Verify Date: _____ Int: _____

Patient Information/Registration Form

Patients Legal Name: _____

Address: _____ City _____

State _____ Zip _____ Home Phone # _____ e-mail Address _____

M S D W: Cell Telephone # _____ Birth Date _____ Age _____
(circle one)

Patients Employer _____ Telephone # _____ Occupation _____

Spouses Name: _____ DOB _____

Spouse's Employer: _____ Phone # _____

In case of emergency contact : _____

Address _____ City _____ State _____ Zip _____

Relationship: _____ Phone Number _____

INSURANCE:

We ask all patients to show their insurance cards so that we may take copies of them.

PAYMENT AUTHORIZATION

I, _____, hereby authorize Women's Health Associates, P.C., to furnish information to insurance carriers concerning my present illness and treatments as long as I am under their care. I direct the insurer to pay, without equivocation, directly to Women's Health Associates, P.C. all benefits due them as a result of this claim. A Photostatic copy of this authorization will be as valid as the original. I understand that I am responsible for all charges including any collection agency fees, court costs, lab fee and any interest applied to outstanding balances. I also understand that payment is due at the time of service unless previous arrangements have been made.

Signature of Patient: _____

Signature of Responsible Party: _____

DO YOU HAVE ANY ALLERGIES TO MEDICATION? _____

Referred to us by: _____