Valley For Women Women, P.C.

480.782.0993

Patient Information Record

Please Print

Patient Name _____ Age _____ Gender ☐M ☐F
Last First Middle Initial

Home Phone _____ Cell Phone _____ DOB _____ SSN _____

Email Address _____ Marital Status ☐S ☐M ☐W ☐D ☐Sep

Street Address _____
City State Zip

Employer _____ Occupation _____ How Long _____

Employer Address _____ Phone _____
City State Zip

Primary Doctor _____ Phone _____

Primary Doctor Address _____
City State Zip

Pharmacy _____ Cross Streets _____ Phone _____

Pharmacy Address _____
City State Zip

Referred by _____

Emergency Contact _____ Relationship _____

Street Address _____ Phone _____
City State Zip

Spouse (or Parent, if minor) _____
Last First Middle Initial

Date of Birth _____ SSN _____ Phone _____

Street Address _____
City State Zip

Employer _____ Occupation _____ How Long _____

Employer Address _____ Phone _____
City State Zip

Primary Insurance Company _____

Street Address _____ Phone _____
City State Zip

ID# _____ Policy# _____ Group# _____

Policyholder's Name _____ Relationship to Patient _____ DOB _____

Policyholder's Address _____ Phone _____
City State Zip

Policyholder's Employer _____ Phone _____

Street Address _____
City State Zip

Other Insurance Company _____

Street Address _____ Phone _____
City State Zip

ID# _____ Policy# _____ Group# _____

Policyholder's Name _____ Relationship to Patient _____ DOB _____

Policyholder's Address _____ Phone _____
City State Zip

Policyholder's Employer _____ Phone _____

Street Address _____
City State Zip

AUTHORIZATION TO RELEASE INFORMATION AND ASSIGNMENT OF BENEFITS

I authorize payments of medical benefits to the provider for services, rendered or to be rendered in the future, without obtaining my signature on each claim submitted, and the signature will bind me as though I personally signed the claim. I also authorize the release of any medical information necessary. I UNDERSTAND I AM RESPONSIBLE FOR ALL CHARGES. If this account should be referred to a collection agency, I will be responsible for any collection and/or legal fees. I have read and understand the office policy and procedures.

_____ _____
Responsible Party Signature Date