PATIENT REGISTRATION UPDATE

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PATIENT INFORMATION Last Name: Maiden or Nickname:	Account#:		Birth Date:
Last Name:	First Name:		MI:
Maiden or Nickname:	Marital Statu	s: Last 4	of SS#:
Address: City:	Q.	tate.	Zip:
Home PH#:	Work	tate: PH#:	Ext:
Cell PH#:		IL Address:	
******			******
SPOUSE OR PARENT'S INFORMATION -			
Spouse or Parent's Name:			
Spouse or Parent's Birth I			
Spouse or Parent's Employed If Employer has changed,	ict name of n	aw Employer.	
ii Empioyei nas changed,	.ISC Hame OI II	ew Emproyer.	
*****	******	*****	*****
EMERGENCY INFORMATION -]	n case of eme	rgency, please	e contact:
Name:	Phone:		
Relationship to Patient:	Primary Ca	re Physician:	
Relationship to Patient: Primary Care Physician: ***********************************			
PATIENT EMPLOYER INFORMATION - Employer Name:			
If Employer has changed,]	ist name of n	ew Employer:	
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AUTHORIZATION FOR TREATMEN	ייי די איז א יביאויי א אז.	ט טיי איי איי איי איי איי איי איי	DEDATIONS _
I authorize the release of			
ment, payment and healthca	re operations	Additional	lv. I authorize
and assign any payment of	medical benef	its to the Phy	sicans for
Women's Health LLC, its su	ccessors and	assigns, or a	ny individual it
may designate for services		_	
As part of this authorizat	ion, Physicia	ns for Women's	Health LLC will
release HIV, Drug and Alcohol, and Mental Health/Psychiatric informa-			
tion as required by law unless otherwise indicated. I understand that I have the right to request that services for which I have paid out-of			
pocket, not be disclosed t			l nave pard odc-or
I agree to pay interest at			nounts 30 days
past due, as well as costs	including at	tornev's fees	associated with
the collection of any amou	ints due for s	ervices rendei	red. I understand
that I am financially resp	onsible to Ph	ysicians for <i>V</i>	Nomen's Health LLC
its successors and assigns	or any indiv	idual it may o	designate, for
amounts owed by me in acco			
acknowledge that I will be	responsible	for all unpaid	d Claims if I fall
to provide insurance infor for services rendered.	mation within	my nearth pro	an's liling limic
		Da	ate:
Signature of Patient:	*****	******	**********
MEDICARE AUTHORIZATION FOR			THCARE OPERATIONS,
MEDICARE RECIPIENTS SIGN E			
I authorize the release of	my medical in	nformation for	purposes of
treatment, payment and hea	Ithcare opera	cions. I requ	lest that payment
of Authorized Medicare ber			
to Physicians for Women's Health LLC for services furnished to me by providers. I authorize any holder of my medical information to			
release to the Centers for	Medicare and	Medicaid Serv	vices and its
agents any information nee	eded to determ	ine benefits 1	for related
services rendered.			
Patient's Signature: ************************************	المالية	Dă	ate:
Notice of Privacy: Receiv	eu	Wernsen	
Signature of Patient/Parer	t of Minor:		Date:
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