



University Women's HealthCare  
 401 E. Chestnut Street, Suite 410  
 Louisville, KY 40202  
 502-271-5999

You have an appointment with Dr. \_\_\_\_\_ at \_\_\_\_\_ on \_\_\_\_/\_\_\_\_/\_\_\_\_

**PLEASE PRINT ENTIRE FORM:**

Patient Name: \_\_\_\_\_ Referred By: \_\_\_\_\_  
 Address: \_\_\_\_\_ Soc. Sec. #: \_\_\_\_/\_\_\_\_/\_\_\_\_  
 City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ Birth Date: \_\_\_\_/\_\_\_\_/\_\_\_\_  
 Phone #: \_\_\_\_\_ Work #: \_\_\_\_\_ Employer: \_\_\_\_\_  
 Cell #: \_\_\_\_\_ Email: \_\_\_\_\_ Occupation: \_\_\_\_\_

Spouse/Parent: \_\_\_\_\_ Soc. Sec. #: \_\_\_\_/\_\_\_\_/\_\_\_\_  
 Address: \_\_\_\_\_ Birth Date: \_\_\_\_/\_\_\_\_/\_\_\_\_  
 City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ Occupation: \_\_\_\_\_  
 Phone #: \_\_\_\_\_ Work #: \_\_\_\_\_ Employer: \_\_\_\_\_  
 Cell #: \_\_\_\_\_ Email: \_\_\_\_\_ Address: \_\_\_\_\_

**Name of nearest relative not living with you:** \_\_\_\_\_ Relationship: \_\_\_\_\_  
 \_\_\_\_\_ Phone #: \_\_\_\_\_  
 Address: \_\_\_\_\_ Work #: \_\_\_\_\_  
 City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ Cell #: \_\_\_\_\_

**AUTHORIZATION TO RELEASE INFORMATION:** I HEREBY AUTHORIZE University Women's Health Care to release any medical or incidental information that may be necessary for either medical care or in processing applications for financial benefit.

**REFERRALS:** You are responsible for obtaining your referral to our office and will be responsible for any denied charges when this is not obtained.

Primary Insurance: \_\_\_\_\_ Secondary Insurance: \_\_\_\_\_  
 Address: \_\_\_\_\_ Address: \_\_\_\_\_  
 Insured Person: \_\_\_\_\_ Insured Person: \_\_\_\_\_  
 Policy Holder: \_\_\_\_\_ Policy Holder: \_\_\_\_\_  
 Group #: \_\_\_\_\_ Certificate #: \_\_\_\_\_ Group #: \_\_\_\_\_ Certificate #: \_\_\_\_\_  
 Effective Date: \_\_\_\_\_ Effective Date: \_\_\_\_\_

Patient is: Self  Spouse  Son  Daughter  Other

**ASSIGNMENT OF INSURANCE BENEFITS:** I HEREBY AUTHORIZE direct payment of surgical/medical benefits to University Women's Health Care for services rendered by them in person or under their supervision. I understand that I am financially responsible for any balance not covered by my insurance.

PATIENT NAME (Print): \_\_\_\_\_ Date: \_\_\_\_\_  
 PATIENT (GUARDIAN) SIGNATURE: \_\_\_\_\_ Date: \_\_\_\_\_

**\*\*A photocopy of these assignments shall be valid as the original.**