



Date \_\_\_\_\_

Patient Name \_\_\_\_\_  
First Middle Last Maiden

Current Address \_\_\_\_\_  
Street city s t zip code

Birth date \_\_\_\_/\_\_\_\_/\_\_\_\_ Age \_\_\_\_\_ Race \_\_\_\_\_ SSN \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Home Phone \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Cell \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Alternate Ph. \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Marital Status \_\_\_\_\_ Spouse's Name \_\_\_\_\_ Spouse SSN \_\_\_\_/\_\_\_\_/\_\_\_\_

Email \_\_\_\_\_ Spouse Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_

Patient's Employer \_\_\_\_\_  
Company Name Address Phone

Spouse Employer \_\_\_\_\_  
Company Name Address Phone

Person to notify incase of Emergency \_\_\_\_\_ Relation \_\_\_\_\_

Address \_\_\_\_\_ Phone \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Referring Physician \_\_\_\_\_ Primary Care Physician \_\_\_\_\_

Pharmacy Name/City/Phone \_\_\_\_\_

**Primary Insurance** \_\_\_\_\_  
Name of Insurance Company Employer

Claim Mailing Address \_\_\_\_\_ Policy Holder \_\_\_\_\_

Member Number /Card Number \_\_\_\_\_ Group Number \_\_\_\_\_ Policy Holder SSN \_\_\_\_\_

Policy Holder Birth Date \_\_\_\_/\_\_\_\_/\_\_\_\_

**Secondary Insurance** \_\_\_\_\_  
Name of Insurance Company Employer

Claim Mailing Address \_\_\_\_\_ Policy Holder \_\_\_\_\_

Member Number/Card Number \_\_\_\_\_ Group Number \_\_\_\_\_ Policy Holder SSN \_\_\_\_\_

Policy Holder Birth Date \_\_\_\_/\_\_\_\_/\_\_\_\_

I hereby authorize Heartland Women's Health, PA to release any records/information needed to process medical/surgical health insurance claims. I also authorize payment of medical/surgical benefits for services performed by Heartland Women's Health, PA providers. I understand that regardless of insurance coverage, I am responsible for payment for any services provided by Heartland Women's Health, PA. A copy of this Authorization is as valid as the original.

Patient/Guardian Signature \_\_\_\_\_