WESTSHORE PRIMARY CARE
WESTSHORE WOMEN'S HEALTH
WESTSHORE MIDWIFERY ASSOCIATES

PATIENT INFORMATION

Name:	**Date of Birth:** **Age:**
Address One:	**Social Security #:**
Address Two:	**Sex:**
City:	**Marital Status:**
State: **Zip:**	**Employer:**
Home Phone #:	**Emergency Contact:**
Work Phone #:	**Emergency Phone#:**
Cell Phone #:	**Emergency Relationship:**
Usual Provider:	**Referring Dr:**
PCP:	**Language: «AdditField3»**
	Race: «AdditField1»
Email:	**Ethnicity:«AdditField2»**
Contact Preference: Phone / Email / Both Phone & Email	
May we leave a message/results on an answering machine? Yes / No ☐ ☐	

GUARANTOR INFORMATION

Name:	**Date of Birth:**
Address One:	**Social Security #:**
Address Two:	
City:	**Employer:**
State: **Zip:**	**Employer Address:**
Home Phone #:	**Employer City:**
Work Phone #:	**Employer State:** **Zip:**
Cell Phone #:	

INSURANCE INFORMATION

Primary Ins:	**Secondary Insurance:**
Certificate #	**Certificate#:**
Group Number:	**Group Number:**
Group Name:	**Group Name:«**
Copay:	**Copay:**
Subscriber Name:	**Subscriber Name:**
Subscriber DOB:	**Subscriber DOB:**

Authorization: I, with my signature, authorize Westshore Primary Care Associates, Inc., (WSPC) and any employee working under the direction of the physician, to provider medical care for me, or to this patient for which I am the legal guardian. I also authorize WSPC to furnish information to the identified insurance carrier(s) for prior authorization, pre-certification or payment of healthcare services. This information may include claims, copies of medical information, faxes and phone calls concerning care provided or proposed. I shall assign all payments for these services to WSPC.

I understand that I am responsible for all co-payments, deductibles, and other amounts deemed my responsibility by the insurance plan, as required by my contract with my insurance plan and state regulations. I further understand that my contract with my healthcare insurance entity may or may not cover some services. It is my responsibility to obtain information from my health plan about service coverage. If I seek care outside the contract, I am aware that I may be responsible for all charges that are incurred.

Patient/Guardian _____ Date _____

☐ I have received a copy of the Notice of Privacy Practices for Westshore Primary Care and/or WSPC Midwifery, WSPC Women's Health