TriHealth Women's Services
Reproductive Endocrinology

# PATIENT INFORMATION

The following information is very important to your health. Please take the time to fully and accurately fill out this form.

| | | | | |
|---|---|---|---|---|
| Name: (First) (Middle) (Last) | | Maiden Name: | Date of Birth: | Social Security Number: |
| Home Address: | City: | State: | Zip Code: | Home Phone: |
| Place of Employment: | Occupation: | | Exten: | Work Phone: |
| Employment Address: | City: | State: | Zip Code: | Cell Phone: |
| Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed | | | E-mail Address: | |

## SPOUSE'S INFORMATION

| | | | | |
|---|---|---|---|---|
| Spouse's Name: | | | Date of Birth: | Social Security Number: |
| Home Address: | City: | State: | Zip Code: | Home Phone: |
| Spouse's Place of Employment: | Occupation: | | Years Employed: | Work Phone: |

## PARENT'S INFORMATION (IF YOU ARE COVERED BY PARENT'S INSURANCE)

| | | | | |
|---|---|---|---|---|
| Parent's Name: | Parent's Home Address: | | City: | State: Zip Code: |
| Parent's Place of Employment: | Parent's Date of Birth: | Work Phone: | | Exten: |

## INSURANCE INFORMATION (PLEASE PROVIDE A COPY OF YOUR INSURANCE CARD TO THE RECEPTIONIST)

| | | | | | |
|---|---|---|---|---|---|
| Primary Insurance Company: | Insured's Name: | | | I.D. Number: | Group Number: |
| Address: | City: | State: | Zip Code: | Phone: | Effective Date: |
| Secondary Insurance Company: | Insured's Name: | | | I.D. Number: | Group Number: |
| Address: | City: | State: | Zip Code: | Phone: | Effective Date: |

## PERSON TO CALL IF NECESSARY

| | | | |
|---|---|---|---|
| Name: | Home Phone: | Work Phone: | Relationship: |

## HOW DID YOU LEARN ABOUT OUR PRACTICE?

| | | |
|---|---|---|
| Name of Physician: | Name of Friend or Relative: | Other (eg: Phone Book, Hospital, Nurse, etc.): |

All professional services rendered are charged to the patient. The patient is responsible for all fees; it is customary to pay for services when rendered unless prior arrangements have been made.

**INSURANCE AUTHORIZATION AND ASSIGNMENT** (Please read and sign): All medical information is strictly confidential: however, I hereby authorize TriHealth Women's Services Reproductive Endocrinology to furnish medical information to my insurance carrier to process claims or to perform internal administrative functions. I hereby assign to the physician, all payments for medical services rendered to myself or my dependents. I understand that I am responsible for any amount not covered by insurance. I agree to pay the balance in full within ten working days.

NAME _____ DATE _____