



Patient Information:

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ Middle: \_\_\_\_\_

Maiden Name: \_\_\_\_\_ Other Name Used: \_\_\_\_\_

SSN: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Marital Status: \_\_\_\_\_

Race: \_\_\_\_\_ Language Preferred: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Cell #: \_\_\_\_\_ Home #: \_\_\_\_\_ Work #: \_\_\_\_\_

Email Address: \_\_\_\_\_@\_\_\_\_\_

Driver's License #: \_\_\_\_\_ State issued by: \_\_\_\_\_

Employer Name & Address: \_\_\_\_\_

Insurance Company Name: \_\_\_\_\_

If Medicaid, who did you select as your HMO? Please circle one: Driscoll, Molina, Superior, United Healthcare, Healthspring, Women's Health Program, Traditional Medicaid, Other, Do not know

Address: \_\_\_\_\_

Policy #: \_\_\_\_\_ Group#: \_\_\_\_\_

Medicaid #: \_\_\_\_\_ Medicare #: \_\_\_\_\_

Are you the policy holder: Yes or No If no: Name of policy holder: \_\_\_\_\_

Relationship to insured: \_\_\_\_\_ DOB: \_\_\_\_\_ SSN: \_\_\_\_\_

Do you have more than 1 insurance policy: Yes or No If yes, insurance company name: \_\_\_\_\_

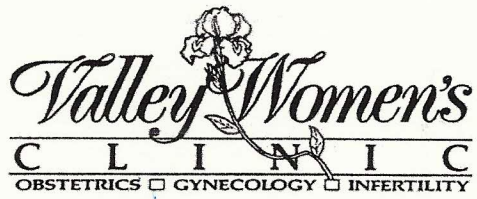
Is this your 1<sup>st</sup> visit to Valley Women's Clinic: Yes or No If no, when was your last visit: \_\_\_\_\_

Emergency Contact Info: \_\_\_\_\_

I certify the above information is correct to the best of my knowledge. I also understand that I am financially responsible for all charges if my insurance does not cover my visits to Valley Women's Clinic.

\_\_\_\_\_  
Patient's Signature

\_\_\_\_\_  
Date



It is your responsibility to inform us of any private health insurance policy you may have. If at any time your insurance company denies payment due to other insurance being primary, you will be held responsible for any unpaid charges. Medicaid is secondary to your private health insurance.

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date