Valley Women's CLINIC
OBSTETRICS ☐ GYNECOLOGY ☐ INFERTILITY

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 1st 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

*1717 Ed Carey Drive, Harlingen, TX. 78550, 956-423-4030, ph – 956-423-9188, fax*

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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