☐ Dr. Anderson
☐ Dr. Smith
☐ Dr. Zivney

☐ Dr. Garant

Affiliates for Women's Health

1602 Rock Prairie Rd. West, Suite 430
College Station, TX 77845

FORM OF PAYMENT FOR VISIT

☐ CASH ☐ CHECK
☐ VISA/MasterCard

PATIENT INFORMATION

DATE:

PATIENT'S NAME (LAST, FIRST, MIDDLE INITIAL)	MARITAL STATUS (S / M / W / DIV / SEP)	DATE OF BIRTH	AGE	SOCIAL SECURITY NO.

STREET ADDRESS ☐ PERMANENT ☐ TEMPORARY	CITY AND STATE	ZIP CODE	HOME PHONE NO.

PATIENT'S EMPLOYER	OCCUPATION (INDICATE IF STUDENT)	HOW LONG EMPLOYED?	BUSINESS PHONE NO.

EMPLOYER'S STREET ADDRESS	PATIENT'S DR. LIC. #

SPOUSE'S NAME	SOCIAL SECURITY NUMBER	DATE OF BIRTH

SPOUSE'S EMPLOYER	BUSINESS PHONE NO.

IN CASE OF EMERGENCY CONTACT: (NAME, ADDRESS & PHONE NO.)

WHO REFERRED YOU TO THIS PRACTICE?	NEAREST RELATIVE NOT LIVING WITH YOU (NAME, ADDRESS & PHONE NO.)

IF THE PATIENT IS A MINOR OR STUDENT

MOTHER'S NAME	ADDRESS	HOME PHONE NO.

MOTHER'S EMPLOYER	BUSINESS PHONE NO.

FATHER'S NAME	ADDRESS	HOME PHONE NO.

FATHER'S EMPLOYER	BUSINESS PHONE NO.

GENERAL CONSENT TO TREAT

I do hereby voluntarily consent to medical/ surgical treatment under the general and specific instructions of Dr. Anderson, Dr. Smith, Dr. Zivney, Dr. Gayle and/or Dr. Garant as is necessary in their judgement. I also acknowledge that the practice of medicine is not an exact science and that no guarantees have been made to me as to the results of treatment or examination.

Patient's Signature: _____ Date: _____

ASSIGNMENT OF BENEFITS

I AUTHORIZE THE RELEASE OF ANY MEDICAL INFORMATION NECESSARY TO PROCESS THIS CLAIM.	I AUTHORIZE PAYMENT OF MEDICAL BENEFITS TO PHYSICIAN.
SIGNED	SIGNED

I understand that I am financially responsible to said doctor for all charges not covered by this assignment.

Insured Name: _____ Date of Birth: _____

Employer: _____ Social Security No. _____