ADAMS PATTERSON
GYNECOLOGY & OBSTETRICS
Women's Care Center of Memphis, MPLLC

PLEASE COMPLETE FRONT AND BACK

CHART # _____

PATIENT HISTORY INFORMATION
(Please Print — Answer All Questions

Date _____

Patient _____ Date of Birth _____ Age ___ Social Security No. _____
Full Name of Patient

Address _____ Home Phone ( ) _____
Street and Number City State Zip Code Area Code

E-Mail Address _____ Cell # ( ) _____
Area Code

Married _____ Single _____ Divorced _____ Widow_____ Preferred #: ☐ Home ☐ Work ☐ Cell

Race: _____ Ethnicity: ☐ Latino/Hispanic Other_____

EMPLOYMENT INFORMATION

Patients Employer _____

Address _____

_____

Work Phone #_____ Position _____

SPOUSE / RESPONSIBLE PARTY
(If minor or on parent's insurance, please give parent's information)

Name _____

Soc. Sec. No. _____

Employer _____

Address _____

_____

Work Phone # _____

Relationship _____

INSURANCE INFORMATION — We also need a copy of your insurance card.

Primary Ins. _____

Insurance Co. Address _____

Name of Policy Holder _____ Date of Birth _____

ID or SS# _____ Group Number _____

Policyholder's Address if Other than Pt. _____

Secondary Ins. _____

Insurance Co. Address _____

Name of Policy Holder _____ Date of Birth _____

ID or SS# _____ Group Number _____

Policyholder's Address if Other than Pt. _____

PHARMACY INFORMATION

Pharmacy: _____ Pharmacy #_____

In case of Emergency — Not Living With You_____
Name Relationship DOB

Address _____ Phone ( ) _____
Street and Number City State Zip Code Area Code

CONSENT FOR CARE

I hereby give my consent for treatment to **Women's Care Center of Memphis, MPLLC (DBA Adams Patterson Gynecology & Obstetrics)**, including treatment or services, and which may include but not be limited to laboratory procedures, examinations, medical treatment or procedures rendered for me/my dependent under the general and specific instructions of the patient's physician.

Signature: _____ Date: _____
Patient

Signature: _____ Date:_____
AND Parent or Guardian (if patient is a minor)

PLEASE TURN OVER

INSURANCE PARTICIPATION, INSURANCE FILING & ACKNOWLEDGEMENT OF FINANCIAL RESPONSIBILITY

The doctors in our group participate in many insurance plans. I understand that if my insurance plan is one the doctors do not participate in, my benefits may be reduced or not cover the services. I understand that my insurance requires specific facilities for lab work, mammography, surgery, etc. Please advise us, and we will try to abide by their requirements. However, we cannot be responsible in the event that lab/testing is done at a non-provider facility. I understand that the office will be happy to file my insurance with an assignment of benefits. Payment for services rendered, however are ultimately the responsibility of the patient and are not contingent upon the insurance settlement. I will be asked to pay deductibles, co-insurance and co-pays prior to or at the time of service. I understand that I will be responsible for any charges if I do not follow the guidelines required by my insurance company.

The information I have given is accurate and true to the best of my knowledge. I understand that I am responsible to pay for services rendered, including reasonable attorney's fees and costs of collection up to 40% of charges in the event of default.

I authorize payment of medical insurance benefits that I have, be paid directly to the above doctors.
I authorize the release of any information necessary to process my claims.

I understand it is my responsibility to let the above doctors know of any change in my address or telephone number.

If I am a minor or filing for benefits through my parent's/guardian's insurance, I authorize you to release information concerning my medical care to my parent(s) or legal guardian. (Patient and responsible party must also sign below.)

Signed_____ Signed_____
Patient and/or Responsible Party's Signature — Patient if minor or insured by parent/guardian

Date _____

INFORMED CONSENT TO RELEASE OR DISCUSS CLINICAL INFORMATION

I authorize the following person (or persons) to receive information regarding clinical or financial affairs while I am a patient of **Women's Care Center of Memphis, MPLLC (DBA Adams Patterson Gynecology & Obstetrics)**. I release Women't Care Center of Memphis, MPLLC (DBA Adams Patterson Gynecology & Obstetrics) from any and all liability regarding privacy of medical, insurance or financial information.

_____Relationship_____

_____Relationship_____

_____Relationship_____

_____Relationship_____

_____Relationship_____

Signature: _____Date:_____
Patient