Westlake Gynecology & Women's Healthcare

PATIENT INFORMATION

Last _________________________First ____________________ MI __ Age___ Birth date_________________

Address __________________________City ____________________________State____ Zip ________________

Home # ____________________Bus# ____________________ Cell # ___________________________________

Employer _____________________ Address __________________________ Phone # ______________________

Social Security# ______________________________ Driver's license _____________________________________

Spouse's Name ___________________________Employer ________________________Work #______________

Emergency Contact ___________________________________ Cell # _____________________________________

Referred by _________________________________ Primary Physician __________________________________

PRIMARY INSURANCE

Name of Subscriber ____

ID# ____________________________________ Group # ____

Responsible party: Self ___________ Spouse _______________ Parent __________________________

SECONDARY INSURANCE

Name ___________________________________ Subscriber ____

ID # ____________________________________ Group # ____

RESPONSIBLE PARTY

Last ______________________________________ First _______________________________ MI ______________

Address ____City _______________State ____ Zip _____________

Occupation _________________________________ Employer's Name ___________________________________

Employer's address _____________________________________ Work # _________________________________

Please remember insurance is considered a method of reimbursing the patient for fees paid to the doctor and is not a substitute for payment. Some companies pay fixed rates and others pay a percentage. It is your responsibility to pay deductibles, co-pays, and unpaid balances.

Method: Cash __________Check _________Credit _________

I agree to assign all medical/surgical benefits to Neeta Ambe-Crain, M.D. and Nancy Taylor, M.D. and understand that I am financially responsible for all charges whether paid or unpaid by insurance. I authorize release of information necessary to secure payment. A photocopy of this document shall be as valid as the original.

SIGNATURE ____ DATE _________________________________