Women's Care Florida D/B/A
North Florida Ob-Gyn

Confidential Patient Information Form - Form must be filled out completely to ensure correct claim processing.

Social Security: _____ **Patient:** _____
(Last) (First) (Middle Initial)

Date of Birth: _____ **Address:** _____
(Street #) (City) (State) (Zip)

Home Tel #: _____ **Work Tel #:** _____ **Patient Cell #:** _____

(If Cell # is provided, the office may text you appointment reminders) **Employer:** _____

Patient E-mail: _____ **Marital Status:** _____ **Employment Status:** _____
(S M D W Sep) *(FT PT Ret N)*

How did you hear about our office? _____ **Student:** _____
(FT PT)

Referring Physician: _____ **Primary Care Physician:** _____

Emergency Contact: _____ **Relationship:** _____ **Phone #:** _____

Pharmacy Name, Phone #, Fax #, and address: _____

Primary Insurance: _____ **Subscriber (Insured) Name:** _____

Subscriber Date of Birth: _____ Social Security #: _____ Employer: _____

ID #: _____ **Group Name & #:** _____ **Patient Relationship to Insured:** _____
(Self, Spouse, Child)

Insurance Address: _____
(Street #) (City) (State) (Zip)

Secondary Insurance: _____ **Subscriber (Insured) Name:** _____

Subscriber Date of Birth: _____ Social Security #: _____ Employer: _____

ID #: _____ **Group Name & #:** _____ **Patient Relationship to Insured:** _____
(Self, Spouse, Child)

Insurance Address: _____
(Street #) (City) (State) (Zip)

I understand that I am directly and primarily responsible to Women's Care Florida, LLC D/B/A/North Florida Ob-Gyn ("Practice") for its customary fee for the services rendered to me by the Practice. I realize that if my insurance company fails to pay or if there is any delay in paying the Practice, it is my responsibility to pay my doctor's bill directly. I further understand and agree if I fail to make timely payments to the Practice, that I will be responsible for any and all reasonable cost of collection including filing fees as well as any reasonable attorney's fee(s).

For the services rendered by the Practice, I authorize the release of any medical or other information necessary to process claims to my insurance carrier. This may include the diagnosis and records in the course of my examination or treatment. I also request payment of government benefits either to myself or the party who accepts assignment (Women's Care Florida, LLC.). I authorize payment of medical benefits to the physician who submits the claim. I agree to hold the Practice harmless from any and all costs, liability and damages of and nature whatsoever including reasonable attorney's fees, resulting directly from the release of my medical records pursuant to this consent. To facilitate the provision of my medical care, I consent for the Practice to access my medical records maintained by any other North Florida Ob-Gyn office.

I understand the office may employ an Advanced Practice Registered Nurse ("APRN"), Midwife ("APRN/CNM") or Physician Assistant ("PA"), and if I am scheduled with them, I am willing to see them instead of the doctor. I hereby consent to and authorize the performance of all appropriate procedures and courses of treatment, the administration of all anesthetics, and any and all medications which in the judgment of my provider may be considered necessary or advisable for my diagnosis and/or treatment. I consent to electronic access to my medication history.

This form was last modified on 05/16/2019. I acknowledge that I have read this authorization and fully understand its contents.

Patient Signature: _____ Date: _____

Responsible Party Signature **(required if patient is under 18):** _____

Relationship of Responsible Party to Patient: _____