MICHIGAN
WOMEN'S HEALTH
A Division of Michigan Healthcare Professionals
WWW.MICHIGANWOMENSOBGYN.COM

FARMINGTON HILLS OFFICE
28555 Orchard Lake Road, Suite 120
Farmington Hills, MI 48334
248.489.1070

CLAWSON OFFICE
909 West Maple, Suite 110
Clawson, MI 48017
248.288.1237

PATIENT INFORMATION

Patient Name: First _____ MI _____ Last _____

Address: Street _____ City _____ State _____ Zip _____

Phone: Home _____ Work _____ Mobile _____

Email: _____

What is your preferred method of contact? ☐ **Home Phone** ☐ **Work Phone** ☐ **Mobile** ☐ **Email**

What is your preferred method of contact for test results? ☐ **Home Phone** ☐ **Work Phone** ☐ **Mobile** ☐ **Email**

Last 4 of SS # _____ **Date of Birth** _____

Ethnicity _____ **Marital Status** _____

Are you allergic to any medications?
If so, what are they? _____

Do you have a latex allergy? _____

Emergency Contact _____ **Relationship to Patient** _____

Emergency Contact Home Phone _____ **Emergency Contact Mobile** _____

How were you referred to the office? ☐ **Friend/Family** ☐ **Physician** ☐ **Insurance** ☐ **Beaumont Referral** ☐ **Social Media** ☐ **Radio**

Primary Care Physician _____

Pharmacy Name _____ **Pharmacy Phone** _____

Pharmacy Address _____

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INSURANCE INFORMATION

Name of Insurance _____

Name of Subscriber _____ **Birthdate** _____

SS # of Subscriber _____ **Employer** _____

Relationship to Subscriber _____

SECONDARY INSURANCE INFORMATION

Name of Insurance _____

Name of Subscriber _____ **Birthdate** _____

SS # of Subscriber _____ **Employer** _____

Relationship to Subscriber _____

Please remember that 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 allowances for certain procedures, and other pay a percentage of the charge. It is your responsibility to pay any deductible amount, co-insurance, or any other balance not paid for by your insurance. In order to control the cost of billings, we request that our charges for office visits be paid at the conclusion of each visit.

I hereby assign all medical and/or surgical benefits to which I am entitled including Medicare. Private insurance and other health plans to: Michigan Women's Health Institute. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I hereby authorize said assignee to release all information to secure the payment, including copies of portions of the patient's records.

Signed _____ **Date** _____

Patient # _____ **(Office Use Only)**