Gynecology Specialists
A Division of Mid-Atlantic Women's Care, PLC
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Patient Information Form

Patient Information

Patient's Name_____
First Middle Last

Address _____
Street Apt. No. City State Zip

Home Ph _____ Cell Ph _____ Social Security No._____

Birth Date _____ Marital Status ❑ Single ❑ Married ❑ Divorced ❑ Widowed
Month Day Year

Email address _____

Employer _____ Phone _____

Employer Address _____
Street Apt. No. City State Zip

Primary Care Physician _____ Referred by _____
First Name Last Name

Person other than spouse, not living with you, to contact in case of emergency (friend, neighbor, relative)
_____ Phone _____

Insurance Information

Primary Insurance Carrier _____ Subscriber Name _____

Policy Number _____ Group Number _____

Secondary Insurance Carrier _____ Subscriber Name _____

Policy Number _____ Group Number _____

Spouse/Guardian Information

Spouse/Guardian _____ Home Phone if different from patient _____

Relationship to Patient _____ Social Security Number _____

Address if different from patient _____

Employer _____ Phone _____

Virginia law authorizes health care providers to test patients for HIV, Hepatitis B and Hepatitis C antibodies when a health care provider is exposed to the blood or other bodily fluids of a patient in a manner which may transmit these viruses. In the event of such an exposure, you will be deemed to have consented to such testing and release of test results to the health care provider who was exposed. You will be informed before your blood is tested and given the results of the tests. Positive tests are required to be reported to the Virginia Department of Health.

I hereby affirm the information above is accurate and do authorize treatment of the above named patient today and on all subsequent visits. I, the undersigned patient or guarantor, agree to be responsible for payment of treatment charges, and I understand that insurance coverage does not relieve me of this responsibility. I will also be responsible for any and all reasonable costs of collection, attorney fees and court costs incurred in the collection of any amount due to Gynecology Specialists. I further agree to the release of all information obtained by Gynecology Specialists to insurance companies or their representatives concerning the above named patient, and assign all benefits from said insurance to Gynecology Specialists.

Patient/Spouse/Guardian Signature _____ Date _____