Trinity Women's Health Care, S.C.

Name: (Last Name) (First Name) (MI) Social Security Number

Address: Street City State Zip

S M D W
Marital Status **e-mail** - for the Portal **Date of Birth**

Home Telephone Number Work Telephone Number Cell Phone Number

Circle - Race: White (not Hispanic or Latin), Asian, Hawaiian, Other Pacific Islander, Black/African American (not Hispanic or Latin), American Indian/Alaska Native, Hispanic/Latino

Circle –Ethnicity: Hispanic/Latino - Not Hispanic/Latino

Pharmacy **Employer**

Name of policy holder if different than the patient: Relationship Date of Birth

Address: if different than the patient Social Security Number

Emergency – Contact (name and relationship)

Emergency Contact Phone: **Home** **Work** **Cell**

Referred by Primary Care Physician Name Office Phone Number

** Primary Insurance claims will be filed on your behalf with correct insurance information.**
Please provide our office with a copy (front & back) of your insurance card
Supplementary/Secondary carriers are filled ONLY for Medicare patients.

The only HMO Trinity Women's Health Care participates with is Fox Valley Medicine. Otherwise If you choose to be seen by the practice, you will be expected to pay in full at the time services are rendered

Assignment & Release:
I herby consent for Trinity Women's Health Care, S.C. to provide me with medical treatment. I authorize the release of medical information contained in my chart to my, and or, the insured's insurance company, in order to process any bills. I authorize the use and disclosure of my private health information for the purpose of: Treatment, Payment, and Healthcare Operations. I authorize payment from my, and or, the insured's insurance company directly to Trinity Women's Health Care, S.C. Should my insurance company deny or not cover charges for "ANY" reason, I am financially responsible for the full amount of the bill.

Should my account be referred to an outside collection agency, I agree to pay the collection fees should I decide to return to this office.

Signature of Patient (or Personal Representative if patient is a minor) **Date**