STRONG Women's Health

STRONG WOMEN'S HEALTH LLC : 705 BOSTON POST ROAD, GUILFORD, CT 06437-2732 (203) 453-1859

Last Name: _____

First Name _____

Middle Name: _____

Address: _____

City: _____ State:____ Zip: _____

Home Phone: _____

Work Phone: _____

Mobile Phone: _____

Date of Birth _____ Sex: ❑ M ❑ F

Social Security No: _____

Patient email: _____

Marital Status: ❑ Married ❑ Single ❑ Divorced ❑ Separated ❑ Widowed ❑ Partner

Race: ❑ Black ❑ White ❑ Hispanic ❑ European ❑ Asian ❑ Korean ❑ Filipino ❑ Japanese ❑ Indian ❑ American Indian ❑ Hawaiian/Pacific Islander

Ethnicity: ❑ Hispanic Latino ❑ Neither Hispanic nor Latino

Preferred Language: _____

Contact Preference: ❑ Home Phone ❑ Work Phone ❑ Mobile ❑ Mail ❑ On-Line Portal

Preferred Pharmacy: _____
(Name / Town / Street)

Preferred Lab: ❑ Quest ❑ Yale ❑ Clinical Lab Partners ❑ LabCorp ❑ Middlesex Hospital ❑ L&M Hospital Pequot

Primary Care Doctor: _____

EMERGENCY CONTACT INFORMATION

Name: _____

Relationship to You: _____

Phone: _____ Mobile: _____

GUARANTOR INFORMATION — *to whom statements are sent*

❑ Same as Patient

Name: _____

Address: _____

Relationship to Patient: _____

Date of Birth: _____ Social Security _____

PRIMARY INSURANCE

Insurance Plan Name: _____

Policy Holder *(if other than patient)* _____

Last Name _____

First Name: _____

Middle Name: _____

Address _____

Date of Birth: _____ Sex: ❑ M ❑ F

Policy Information: _____

Patient's relationship to Policy Holder: _____

ID/Certification No.: _____

Policy/Group No.: _____

City: _____ State:_____ Zip:_____

Employer Name: _____

SECONDARY Insurance

Insurance Plan Name: _____

Policy Holder *(if other than patient)* _____

Last Name _____

First Name: _____

Middle Name: _____

Address _____

Date of Birth: _____ Sex: ❑ M ❑ F

Policy Information: _____

Patient's relationship to Policy Holder: _____

ID/Certification No.: _____

Policy/Group No.: _____

City: _____ State:_____ Zip:_____

Employer Name: _____

ASSIGNMENT OF BENEFITS, RELEASE OF INFORMATION and other Authorizations:

- I hereby assign my insurance benefits to be paid directly to the physician.
- I understand that I am financially responsible for all non-covered services, co-pays, deductibles and/or coinsurance.
- I authorize and give consent for my provider to bill me directly for recommended services performed that are not covered under the terms of my health plan.
- I authorize the physician to release any medical information required to process this claim.
- I authorize my provider's office to contact me by telephone to remind me of my appointments.
- I authorize my provider's office to query Pharmacy records electronically to maximize accuracy of my medical record. I give SWH permission to download my results from YNHH's EPIC computer.
- I realize that a fee for "no show" (rather than appointment cancellation) may apply.

Signature: _____ Print Name: _____ Date: _____