NAME _____ BIRTHDATE _____ AGE _____
PLEASE USE FULL NAME (NO NICKNAMES)

ADDRESS (street)_____ (City, State, Zip) _____

CELL PHONE : (_____)_____ EMAIL ADDRESS :_____

HOME PHONE : (_____)_____ or ☐ no home phone

ETHNIC ORIGIN: (circle) Caucasian African American Hispanic Asian Native American Other:_____

HOW WERE YOU REFERRED HERE ? _____

OCCUPATION : _____ Marital Status (circle): SINGLE MARRIED WIDOW DIV SEP

BUSINESS NAME AND ADDRESS _____

_____PHONE #_(_____)_____

IF MARRIED, PARTNER'S NAME _____PHONE #_(_____)_____

Emergency Contact: Name _____ Relationship: _____ Phone: _____
(if other than spouse)

Primary Care Doctor, if applicable: _____

Phone (_____)_____ Fax (_____)_____

PRIMARY INSURANCE COMPANY NAME : _____

SECONDARY INSURANCE COMPANY NAME : _____
(Please print "NONE" if you are covered by only one policy)

SOCIAL SECURITY # _____

PHARMACY : Name : _____ Phone # : _____

Pharmacy address/location if known: _____

I authorize New Age Women's Health LLC to charge the following credit card for any outstanding balance due to non-payment, insurance termination, denial, or inadequate coverage :

(circle) MASTERCARD VISA Name on card : _____ exp date : _____

CARD # : _____ Billing address zip code : _____

G U A R A N T E E O F P A Y M E N T

I fully understand that I am directly responsible for payment to New Age Women's Health LLC for all medical and surgical services rendered to me. I also understand that all bills are payable and become due at the time services are rendered, unless other arrangements have been made. I agree to pay for all collection costs, including reasonable attorney's fees and costs, in the event that it becomes necessary to file suit to effect payment.

A U T H O R I Z A T I O N T O R E L E A S E I N F O R M A T I O N

I hereby authorize the Physicians in this office to release any information acquired in the course of my examination or treatment to my insurance company for the purposes of processing any insurance claims.

A S S I G N M E N T O F I N S U R A N C E B E N E F I T S

If insurance claims are filed by this office on my behalf, I hereby authorize direct payment of any benefits to New Age Women's Health LLC for medical or surgical treatment received by me. I understand that I am financially responsible for any charges not covered by insurance.

M A L P R A C T I C E I N S U R A N C E

Under Florida law, physicians are generally required to carry medical malpractice insurance or otherwise demonstrate financial responsibility to cover potential claims for medical malpractice. The physicians in this office, have decided not to carry malpractice insurance. This is permitted under Florida law subject to certain conditions. Florida law imposes penalties against noninsured physicians who fail to satisfy adverse judgments arising from claims of medical malpractice. This notice is provided pursuant to Florida law.

TODAY'S DATE _____ _____

Patient's signature **(or parent if patient is a minor)**