

PATIENT INFORMATION

Patient Name: _____ Home Phone: _____ Mobile Phone _____
Address: _____
City: _____ State: _____ Zip: _____
Date of Birth: _____ Social Security#: _____
Single Married Divorced Widowed
Retired Yes No /Date of Retirement: _____ Disabled Yes No /Date of Disability: _____
Patient's Employer: _____ Occupation: _____
Employer Address: _____ Wk. Phone: _____
City: _____ State: _____ Zip: _____
Have you ever seen Dr. Gex before? yes ___ no ___ Advance Directive yes ___ no ___ Copy for Dr. yes ___ no ___
Emergency Contact: Name _____ Tel# _____ Relationship _____
Referred by: _____ Yellow Pages Spanish Yellow Pages Website

**IF DIFFERENT FROM ABOVE – POLICY HOLDER/INSURED INFORMATION (person responsible for bill)
Primary Insurance – PLEASE FILL OUT ALL INFORMATION BELOW**

Primary Insurance: _____ Phone: _____
Claims Address: _____ State: _____ Zip: _____
Group#: _____ Policy#: _____
Insured Name: _____ Phone: _____
Address: _____
City: _____ State: _____ Zip: _____
Date of Birth: _____ Social Security#: _____
Employer: _____ Wk. Phone: _____
Employer Address: _____
City: _____ State: _____ Zip: _____

INSURANCE COMPANY INFORMATION – Secondary Insurance

Secondary Insurance: _____ Phone: _____
Claims Address: _____ State: _____ Zip: _____
Group#: _____ Policy#: _____

AUTHORIZATION TO RELEASE INFORMATION & ASSIGNMENT OF BENEFITS

The above information is complete and correct. I authorize release of information necessary to file a claim with my insurance company and I assign benefits to Gex Women's Care PC. We will gladly file your insurance claim, however payment for copays and deductibles are required at the time services are rendered. We cannot guarantee payment to Gex Women's Care PC. We have an agreement with you, not your insurance company for payment. In the event your insurance company denies a claim, you will become responsible for all amounts not covered payable to Gex Women's Care PC. Parents/Guardians are responsible for services rendered to a minor. If your account is turned over for outside collections, you will be responsible for all costs of the outside collection agency.

I authorize release of all medical records to referring and primary care physicians and the insurance company, as applicable. I authorize fax transmission of medical records of necessary.

SIGNATURE: _____ Date: _____