Women's Health Care Group
OBSTETRICS & GYNECOLOGY
LIFE • GROWTH • STRENGTH • PEACE

870 Palisade Avenue, Suite 301
Teaneck, NJ 07666
Phone: 201.907.0900
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whcgnj.com

Patient Information

Patient's Last Name: _____ First Name: _____ MI: _____

Address: _____ Apt #: _____

City: _____ State: _____ Zip: _____

Home Phone: (_____) _____–_____ Work Phone: (_____) _____–_____ ext: _____

Cell Phone: (_____) _____–_____ Date of Birth: ____ /____ /_____ Social Security #: _____–____–_____

Marital Status: ❍ Single ❍ Married ❍ Widowed ❍ Separated ❍ Divorced

Emergency Contact: _____ Relationship: _____ Phone: (_____) _____–_____

Primary Reason for Visit: _____

Referring Doctor: _____ Phone: (_____) _____–_____

Pharmacy: _____ Phone: (_____) _____–_____ Fax: (_____) _____–_____

Employer Information

Name of Employer: _____ Address: _____

City: _____ State: _____ Zip: _____ Phone: (_____) _____–_____

Occupation: _____ May we contact you at work? ❍ Yes ❍ No

Primary Insurance (copy of card will be attached)

Primary Insurance Name: _____ Phone: (_____) _____–_____

Address: _____ City: _____ State: _____ Zip: _____

Policy #: _____ Group #: _____ Copay $_____ Effective Date: _____/_____/_____

Name of Insured: _____ Relationship to Patient: ❍ Self ❍ Spouse ❍ Child ❍ Other _____

Insured Date of Birth: _____ /_____ /_____ Insured Social Security #: _____–____–_____

Secondary Insurance

Secondary Insurance Name: _____ Phone: (_____) _____–_____

Address: _____ City: _____ State: _____ Zip: _____

Policy #: _____ Group #: _____ Copay $_____ Effective Date: _____/_____/_____

Name of Insured: _____ Relationship to Patient: ❍ Self ❍ Spouse ❍ Child ❍ Other _____

Insured Date of Birth: _____ /_____ /_____ Insured Social Security #: _____–_____–_____

1. I authorize the release of any medical information necessary to process my insurance claim(s) to Millennium Practice Management Associates, Inc.
2. I authorize and request payment of medical benefits directly to my physician(s) at Women's Health Care Group.
3. I agree that a photocopy of this form may be used in lieu of the original.
4. I agree to pay all charges not covered by my insurance carrier(s). These charges include, but are not limited to deductibles, co-payments, co-insurance and non-covered services.

X _____ _____ /_____ /_____

Patient / Authorized Signature — Date