GALLATIN WOMEN'S CENTER, PC

R. Alan Bennett, M.D., FACOG
John Trussell, M.D., FACOG
Timothy Johnson, DO

Brad Leath, M.D.
Rachel Walker, WHNP

Date: ________________

PATIENT INFORMATION

Patient's Name (Last, First, Middle): ____

Address: ____

(Street) *(City)* *(State)* *(Zip)*

Home Phone: ___________________ Cell Phone:____________________ Email Address:____________________

Social Security #:__________________Date of Birth: _____/_____/_____ Marital Status: Single Married Divorced Widow

Employer: ____ Work Phone: _____________________

Primary Care Provider: _______________________________________ Phone:__________________________

Preferred Pharmacy: ____ Phone:__________________________

SPOUSE/SIGNIFICANT OTHER

Name:____ Relationship:_____________________

Employer:____ Date of Birth: _____/_____/_____

PRIMARY INSURANCE

Subscriber: ____ Date of Birth: _____/_____/_____

Relationship to Patient: _______________________________________

Name of Insurance Company : ____

SECONDARY INSURANCE

Subscriber: ____ Date of Birth: _____/_____/_____

Relationship to Patient: _______________________________________

Name of Insurance Company: ____

ASSIGNMENT & RELEASE

I authorize Gallatin Women's Center to release any medical records necessary to process insurance claims, requests from attorney's or referring physicians. I authorize payment of insurance benefits to be paid directly to Gallatin Women's Center and understand I am financially responsible for payment of services rendered, regardless of insurance coverage or third-party involvement. In the event that my account is placed with an outside agency for collection, I agree to pay all collection costs, court costs and attorney fees incurred to collect my account.

Signature of Patient or Guarantor if patient is under 18 years of age.

____ ______________________

Signature Date

____ ______________________

Printed Name Relationship to Patient