Professional Women's Healthcare, P.A.
103 Hunt Drive Dunn, NC 28334
www.pwhealthcare.com
Ph. 910-897-7711 Fax 910-897-2654

PATIENT INFORMATION

Last Name: _____ First Name: _____ MI: ____

Date of Birth: _____ SSN: _____ Marital Status: S__ M __ D __ Sep __ W __

Mailing Address: _____ City _____ State _____ Zip _____

County: _____ Phone: _____ H/C/W 2nd Phone: _____ H/C/W

Email: _____ Pharmacy _____

Language: _____ Ethnicity: Hispanic or Latino _____ Non-Hispanic or Latino _____

Race (may pick 2): Asian ____ Caucasian _____ Black / Afr. Amer. _____ Amer. Indian _____ Hawaiian ___ Pac. Isl. ___

If patient is a minor, Guarantor's Name: _____ DOB: _____

Guarantor's Address: _____

Phone: _____ SSN: _____ Relationship to pt: _____

YOU MUST INFORM THIS OFFICE OF ALL INSURANCE POLICIES YOU HAVE. IF YOUR CLAIMS ARE NOT FILED CORRECTLY, YOU WILL BE RESPONSIBLE FOR PAYMENT

Primary Insurance Company: _____

Policy # _____ Group # _____

Policy Holder _____ Policy Holder's DOB _____ Relationship _____

Secondary Insurance Company: _____

Policy # _____ Group # _____

Policy Holder _____ Policy Holder's DOB _____ Relationship _____

Contact Persons In Case of Emergency:

Name _____ Phone _____ Relationship _____

Name _____ Phone _____ Relationship _____

ALL CHARGES ARE DUE AT THE TIME OF SERVICE. ALL PROFESSIONAL CHARGES RENDERED ARE CHARGED TO THE PATIENT. DIAGNOSTIC RECEIPTS WILL BE FURNISHED UPON REQUEST.

I AUTHORIZE THOMAS GIEBNANNS, MD AND PROFESSIONAL WOMEN'S HEALTHCARE TO RELEASE MEDICAL INFORMATION TO SUBMIT INSURANCE CLAIMS AND FOR OTHER PHYSICIAN'S REQUESTS RELATING TO MY MEDICAL CARE. I AUTHORIZE PAYMENT OF INSURANCE BENEFITS FOR ANY PROFESSIONAL CHARGES DIRECTLY TO THOMAS GIEBMANNS, MD AND PROFESSIONAL WOMEN'S HEALTHCARE. I UNDERSTAND THAT I AM RESPONSIBLE FOR ANY AMOUNT NOT COVERED BY MY INSURANCE.

Signature _____ Date _____