

BETHANY
WOMENS HEALTHCARE



Alan Schapker, MD
 Rafael Martin, MD
 Scott Schapker, MD
 Claudia Chambers, MD

Lylaine Gavette, CNM
 Lynnette Casey, CNM
 Tiffany Jackson, CNM
 Lisa Sherwood, CNM
 Jeanene Traynor, WHNP

PLEASE FILL IN ALL AREAS:

LAST		FIRST		MI	Date of Birth	Age
Patients Name						
Address					Home Phone	
City		State		Zip	Cell Phone	
S.S.#	Religion		Marital Status		E-Mail Address	
Employer			Occupation		Work Phone	
Employer Address				City	State	Zip
Referred to office by					Phone	

Name of () Spouse () Father of Baby			Soc Sec. No			
Employer		Occupation			Work Phone	
Employer Address				City	State	Zip

Parent, Friend, or relative not living with you (in the event of an emergency)

Name		Relationship	Phone
Address		City	State

Insurance Information

Insurance Company			Phone
Claims Mailing Address			
City		State	Zip
Insured's Name		Relationship to you	Insured's DOB
ID/SS #		Group/Pol#	Copay Amount
When did you become effective on this Insurance:			Is this your primary Insurance:

Secondary Insurance Information

Insurance Company			Phone
Claims Mailing Address			
City		State	Zip
Insured's Name		Relationship to you	Insured's DOB
ID/SS #		Group/Pol#	Copay Amount
When did you become effective on this Insurance:			

Are you pregnant? YES ___ NO ___ Reason for today's visit: _____

I authorize treatment of the patient named above and agree to pay all fees and charges for such treatment promptly upon presentation of the statement unless credit arrangements are agreed upon in writing. I authorize insurance benefits to be paid directly to Bethany Womens Healthcare, P.C. and I am financially responsible for non-covered services. I authorize the release of any information required in the process of this claim. In the event it becomes necessary, I authorize Bethany Womens Healthcare to file a claim with Arizona State Commissioner on my behalf.

SIGNATURE OF RESPONSIBLE PARTY: _____ DATE: _____

Receptionist Initials: _____ Dates info verified: _____



Bethany Women's Healthcare

Acknowledgment of Receipt of Privacy Notice
Original to be maintained in Patient's permanent medical record.

I acknowledge that I have received a copy of the office's Notice of Privacy Practices.

Patient or legally authorized individual signature

Date

Printed Name if signed on behalf of the patient

Relationship (parent, legal guardian, personal representative, etc.)

I am aware that ADVANCED DIRECTIVES are available to me.
(Living Will, Medical Power of Attorney)

I have requested additional information.

I have declined additional information.