WOMEN'S WELLNESS CENTER
OBSTETRICS | GYNECOLOGY | WELLNESS

Serenity MEDICAL AESTHETICS

The Women's Wellness Center

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Patricia Chen, MD, FACOG

Patient Information Sheet

Date: _____

Name: _____ _____ Date of Birth: _____
First Last

What is your primary language?: _____
Marital Status: ☐ single ☐ married ☐ divorced ☐ widowed
Street Address: _____
City: _____ State: _____ Zip: _____
Home Phone: ( ) - E-Mail: _____
Cell Phone: ( ) -
Employer: _____ Occupation: _____
Work Phone: ( ) - Extension: _____
Emergency Contact: _____ Phone: ( ) -
Which Pharmacy do you use?: _____ Phone: ( ) -
How did you find us: ☐ Referral from a Doctor Name: _____
☐ Referral from a Patient Name: _____
☐ Yellow Pages (print edition)
☐ Internet Search Engine Which one?: _____
☐ Other: _____

Insurance Information

Primary Ins. Co: _____	Secondary: _____
ID #: _____	ID #: _____
Group #: _____	Group #: _____
Subscriber: _____	Subscriber: _____
(check one) ☐ Self ☐ Spouse ☐ Dependent	(check one) ☐ Self ☐ Spouse ☐ Dependent
SS# or Date of Birth: _____	SS# or Date of Birth: _____
Ins. Co. Phone: ( ) -	Ins. Co. Phone: ( ) -
Primary Care Provider: _____	Primary Care Provider: _____

Statement of Financial Responsibility

I certify that the above information is correct and further authorize the release of any medical information to my insurance carriers for any claim. I request payment of authorized benefits to the physician furnishing the service, or authorize the physician to submit a claim for me. I, the undersigned, realize that all medical and surgical charges incurred by me or my dependents for services rendered by Drs. Harris, Chen and Pezzullo-Burgs are my financial responsibility. I also agree that should my account be referred to any agency or attorney for collection, I will be responsible for all attorney fees, collection fees, and court costs. I understand that payment is expected when services are rendered, unless prior arrangements have been made.

Signature: _____ Date: _____

Medicare Lifetime Authorization

I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediaries or carriers any information needed for this or a related Medicare claim. I request that payment of authorized benefits be made on my behalf. I assign the benefits payable for physician services to the physician or organization furnishing the services or authorize such physician or organization to submit a claim to Medicare for payment.

Signature: _____ Date: _____