

Associates for WOMEN'S MEDICINE

Renee M. Bender, DO
William F. Brazerol, MD
Christina E. Ellis, MD
Corazon Gemil, MD
Eduardo Mercurio, MD

Exton Office
Commons at Oaklands
728 W. Lincoln Highway
Exton, PA 19341

West Chester Office
600 East Marshall Street
Suite 205
West Chester, PA 19380

West Grove Office
105 Vineyard Way
Suite 102
West Grove, PA 19390

T 610-903-6200
F 610-903-6201
E info@afwmedicine.com
W www.afwmedicine.com

Patient Information

Name _____

Mailing Address _____

Phone (home) _____

(Work) _____

(Cell) _____

E-mail _____

Date of Birth _____ Age _____

SS # _____

Marital Status: Married Single Other

Employed: Full-time Part-time Not currently

Full-time Student Part-time Student

Employer/School _____

Address _____

City _____

State _____

Primary Care Doctor _____

Address _____

Phone _____

Fax _____

Emergency Contact Information

Contact Name _____

Home Number _____

Primary Insurance

Company _____

Policy or ID # _____

Group # _____

Insurance Co. Address _____

Subscriber Name _____

Subscriber Social Security _____

Subscriber Date of Birth _____

Address _____

Employer _____

Secondary Insurance Co. _____

Policy or ID # _____

Group # _____

Insurance Co Address _____

Subscriber Name _____

Subscriber Social Security _____

Subscriber Date of Birth _____

Employer _____

Pharmacy Name _____

Pharmacy Phone Number _____

Relationship _____

Work Number _____

I authorize my insurance benefits be paid directly to the Women's Specialty Center. I request that payment of authorized Medicare benefits be made either to me or on my behalf to the Physician or Supplier for any services furnished to me by the Physician or Supplier. I understand I am responsible for services considered not covered by my insurance company. I understand that I may also be responsible for payment for services performed without the appropriate referral/authorization.

I authorize any holder of medical information about me to release my medical record and pertinent information to my insurer or CMS and its agent if requested to determine benefits or the benefits payable for related services or a claim.

I have been offered a copy to review or I was given a copy of the HIPAA Notice of Privacy Practices.

Signature _____

Date _____