My WOMEN'S CENTER
Gyn. Health. Beauty. Joy.

1441 Pullman Drive
Sparks, NV 89434
P: 775-432-1343
F: 775-324-0858
mwcnv.com

Referred By:_____

Patient Name:_____ Age:_____
Last First MI

Date of Birth:_____ Are you: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Mailing Address:_____ City:_____ State:_____ Zip:_____

Street Address:_____ City:_____ State:_____ Zip:_____

Home Phone:_____ Cell Phone: _____ E-mail:_____

Social Security #:_____ Maiden Name:_____

Employer:_____ Position Occupied:_____ Work Phone:_____

Employer Address:_____ City:_____ State:_____ Zip:_____

Spouse/Parent:_____ Date of Birth:_____

Cell Phone:_____ Employer:_____

Employer Address:_____ City:_____ State:_____ Zip:_____

Emergency Contact:_____ Phone: _____

Do you have any advanced directives (Living Will)? ☐ Yes ☐ No ***If yes, please allow our office to keep a copy.**

In the event of a life-threatening emergency, is there moral, religious or other convictions that would prevent you from accepting a blood transfusion? ☐ Yes ☐ No

Primary Insurance:_____ Subscriber:_____ ID:_____ Group:_____

Secondary Insurance:_____ Subscriber:_____ ID:_____ Group:_____

I hereby authorize Dr. Elizabeth Hutson's office to furnish information to insurance carriers concerning my illness and treatment and I hereby assign the physician all payments for medical services rendered to myself or my dependents. I understand that I am financially responsible for the unpaid balance of my account in the event that my insurance does not pay the account in full. I further state that I have read the information sheet and understand and will comply with the policy set forth.

We will mail you Normal test results and call with Abnormal test results.

☐ **DO NOT MAIL**, please call me with normal results and leave a voicemail.
☐ **DO NOT** leave a message on my phone other than to call your office.
☐ You have permission to leave information with_____

Patient Signature:_____ Date:_____

*Most insurance carriers require that the insured use a contracted facility (hospital, lab, radiology, etc.). In order to obtain maximum benefits, you should contact your insurance company, to find which facilities are contracted prior to receiving services. These contracted facilities change on a regular basis. **It is your responsibility to advise us of the contracted facility to be used.**

***It is also your responsibility to know your co-pays and co-insurance costs for office visits.**