ALL FEMCARE PROFESSIONALS
HUGO L. PEREZ, M.D.
JOSE L. CALDERON, M.D.

Please complete entire form. All information will be kept confidential.

Patient Name ______________________________ **Language** ______________

Date of Birth ______________ **Social Security Number** ______________________

Marital Status ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Street Address ______________________________ **Unit #** ______________

City ______________________ **State** ________ **Zip Code** ______________

Home Phone #(____) ______________ **Cell/Beeper #(____)** ______________

If married, spouse's name ______________ **Cell/Work #(____)** ______________

Employment/School Information

Employer's Name ______________________________ ☐ Part Time ☐ Full Time

Occupation ______________________ **Phone (____)** ______________ **Ext** ________

If student, School/College Name ______________ ______________ ☐ Part Time ☐ Full Time

Emergency Contact Information of Person NOT living with you

Name ______________________________ **Relationship** ______________

Hm Phone #(____) ______________ **Cell #(____)** ______________ **Wk #(____)** ______________

Insurance Information

PRIMARY Insurance Co. ____

Policy Holder's Name ______________________________ **Date of Birth** ______________

Patient Relationship to policyholder ☐ Self ☐ Spouse ☐ Child ☐ Other

SECONDARY Insurance Co. ____

Policy Holder's Name ______________________________ **Date of Birth** ______________

Patient Relationship to policyholder ☐ Self ☐ Spouse ☐ Child ☐ Other

Primary Care Physician

Name ______________________________ **Phone #(____)** ______________
First Last

Please read the following authorization and sign where indicated. I understand and agree that I am responsible for all charges incurred whether or not paid by the above stated insurance, including appointments cancelled without 24 hours notice. I hereby authorize this office to release any and all information necessary to secure reimbursement from any insurance company to which I have subscribed. I hereby authorize and direct payment to All Femcare OB GYN Center, *for medical and/or surgical benefits, if any, otherwise payable to me under the terms of my insurance.*

I understand that Medicaid is only accepted for pregnancy. Medicaid is not accepted as a secondary source of insurance under any circumstances.

✕ ______________________________ ______________

Signature of patient or parent/guardian if minor **Today's Date**

I have received a copy of the office's HIPPA Privacy Notice.

✕ ______________________________ ______________

Signature of patient **Today's Date**

Who may we thank for referring you? ______________________________