



1720 Nicholasville Rd, 4th Floor  
 Central Baptist Hospital  
 Lexington, KY 40503-1413  
 859.278.0363  
 WomensCareCenter.com

CHART/ACCT # \_\_\_\_\_

PLEASE PRINT

NAME \_\_\_\_\_  
LAST FIRST MIDDLE

ADDRESS \_\_\_\_\_  
APT#

CITY \_\_\_\_\_ ST \_\_\_\_\_ ZIP \_\_\_\_\_

SS# \_\_\_\_\_ BIRTH DATE \_\_\_\_\_ AGE \_\_\_\_\_

MARITAL STATUS  SINGLE  MARRIED  DIVORCED  SEPARATED  WIDOWED

PHONE# \_\_\_\_\_ CELL# \_\_\_\_\_

EMAIL \_\_\_\_\_

PREFERRED METHOD OF CONTACT  PHONE  EMAIL  TEXT

EMPLOYER \_\_\_\_\_

OCCUPATION \_\_\_\_\_

WORK PHONE# \_\_\_\_\_ EXTENSION \_\_\_\_\_

EMPLOYMENT STATUS  ACTIVE MILITARY  FT  PT  RETIRED  SELF-EMP  UNEMP

PRIMARY CARE PHYSICIAN \_\_\_\_\_  
FIRST AND LAST NAME PHYSICIAN'S ADDRESS

REFERRED BY \_\_\_\_\_

PREFERRED PHARMACY \_\_\_\_\_ ADDRESS \_\_\_\_\_

**FAMILY INFORMATION/EMERGENCY CONTACT**

SPOUSE \_\_\_\_\_

SPOUSE EMPLOYER \_\_\_\_\_

SPOUSE OCCUPATION \_\_\_\_\_

SPOUSE WORK PHONE# \_\_\_\_\_ EXTENSION \_\_\_\_\_

**IF PATIENT IS A MINOR, PLEASE COMPLETE**

PARENT/GUARDIAN \_\_\_\_\_ RELATIONSHIP \_\_\_\_\_

ADDRESS \_\_\_\_\_

CITY \_\_\_\_\_ ST \_\_\_\_\_ ZIP \_\_\_\_\_ PHONE# \_\_\_\_\_

**INSURANCE POLICY HOLDER INFORMATION**

*Please give receptionist insurance card to copy*

PRIMARY INSURANCE NAME \_\_\_\_\_

POLICY OWNER *(If different than patient)* \_\_\_\_\_

SS# *(Insurance holder)* \_\_\_\_\_

BIRTH DATE *(Insurance holder)* \_\_\_\_\_

EMPLOYER \_\_\_\_\_

WORK PHONE# \_\_\_\_\_

*Secondary Insurance Information (If different than patient)*

*Please give receptionist insurance card to copy*

SECONDARY INSURANCE NAME \_\_\_\_\_

SECONDARY POLICY OWNER *(If different than patient)* \_\_\_\_\_

SS# *(Insurance holder)* \_\_\_\_\_

BIRTH DATE *(Insurance holder)* \_\_\_\_\_

CHILDREN AND AGE

1) \_\_\_\_\_

2) \_\_\_\_\_

3) \_\_\_\_\_

**PATIENT'S AUTHORIZATION TO RELEASE MEDICAL INFORMATION & CLAIM PAYMENT**

I hereby authorize Women's Care Center physicians to release any information to my insurance company regarding services provided by them. I understand that a photocopy of my signature below will be used to file my insurance claim. I authorize and direct my insurance company to issue payment for benefits due me for services rendered by Women's Care Center physicians directly to them. I understand I am responsible for the payment for the services rendered. Accounts may be referred to a collection agency or for legal action if the financial obligation cannot be resolved.

DATE \_\_\_\_\_ PATIENT (PARENT OR GUARDIAN) SIGNATURE \_\_\_\_\_