

# ALL WOMEN'S CARE, PLLC

1033 East Lamar Alexander Parkway  
Maryville, TN 37804

Phone (865) 681-0103  
Fax (865) 681-9840

DATE: \_\_\_\_\_ SOCIAL SECURITY NUMBER: \_\_\_\_\_

PATIENT NAME: \_\_\_\_\_

ADDRESS: \_\_\_\_\_ CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_

PHONE: (HOME) \_\_\_\_\_ (WORK) \_\_\_\_\_ MARITAL STATUS S M D SEP

DATE OF BIRTH: \_\_\_\_\_ PLACE OF EMPLOYMENT \_\_\_\_\_ STUDENT? Y / N

SPOUSE'S NAME: \_\_\_\_\_ DATE OF BIRTH: \_\_\_\_\_ SOCIAL SECURITY # \_\_\_\_\_

PLACE OF EMPLOYMENT: \_\_\_\_\_

PERSON TO CONTACT IN CASE OF AN EMERGENCY OTHER THAN SPOUSE

NAME: \_\_\_\_\_ PHONE: \_\_\_\_\_

REFERRED BY: \_\_\_\_\_ PHONE: \_\_\_\_\_

## INSURANCE INFORMATION

PRIMARY INSURANCE: \_\_\_\_\_ SECONDARY INSURANCE: \_\_\_\_\_

**IF YOU ARE A STUDENT, WHOSE INSURANCE IS PRIMARY?**

NAME: \_\_\_\_\_ DATE OF BIRTH: \_\_\_\_\_

## ASSIGNMENT OF BENEFITS AND FINANCIAL AGREEMENT

I hereby give lifetime authorization for payment of insurance benefits to be made directly to All Women's Care, PLLC, and any assisting physicians, for services rendered. I understand that I am financially responsible for all charges whether or not they are covered by insurance. In the event of default, I agree to pay all costs of collection, and reasonable attorney's fees. I hereby authorize this healthcare provider to release all information necessary to secure the payment of benefits.

I further agree that a photocopy of this agreement shall be as valid as the original:

Date: \_\_\_\_\_ Your Signature: \_\_\_\_\_