WOMEN'S WELLNESS CENTER
OBSTETRICS | GYNECOLOGY | WELLNESS

Serenity MEDICAL AESTHETICS

The Women's Wellness Center

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Patient Information Sheet

Date: ______

☐ **There have been no changes to this information since my last visit** (Please provide your insurance card and identification at check-in, and sign the **"Statement of Financial Responsibility"** at the bottom)

Name: ____________________ ____________________ Date of Birth: ______________
First Last

Social Security #: ____ - ____ - ________ What is your primary language?: ____________

Marital Status: ☐ single ☐ married ☐ divorced ☐ widowed

Street Address: ____

City: ______________________ State: __________________ Zip: ____________

Home Phone: ( ) - __________ E-Mail: ______________________________

Cell Phone: ( ) - __________

Employer: ____________________ Occupation: ______________________________

Work Phone: ( ) - __________ Extension: ______________________________

Emergency Contact: ______________________________ Phone: ( ) - __________

Which Pharmacy do you use?: ______________________ Phone: ( ) - __________

How did you find us:
☐ Referral from a Doctor Name: ______________________
☐ Referral from a Patient Name: ______________________
☐ Yellow Pages (print edition)
☐ Internet Search Engine Which one?: ______________________
☐ Other: ____

Insurance Information

Primary Ins. Co: ______________________ Secondary: ______________________

ID #: ______________________ ID #: ______________________

Group #: ______________________ Group #: ______________________

Subscriber: ______________________ Subscriber: ______________________

(check one) ☐ Self ☐ Spouse ☐ Dependent (check one) ☐ Self ☐ Spouse ☐ Dependent

SS# or Date of Birth: ______________ SS# or Date of Birth: ______________

Ins. Co. Phone: ( ) - __________ Ins. Co. Phone: ( ) - __________

Primary Care Provider: ______________ Primary Care Provider: ______________

Statement of Financial Responsibility

I certify that the above information is correct and further authorize the release of any medical information to my insurance carriers for any claim. I request payment of authorized benefits to the physician furnishing the service, or authorize the physician to submit a claim for me. I, the undersigned, realize that all medical and surgical charges incurred by me or my dependents for services rendered by Drs. Harris and Pezzullo-Burgs are my financial responsibility. I also agree that should my account be referred to any agency or attorney for collection, I will be responsible for all attorney fees, collection fees, and court costs. I understand that payment is expected when services are rendered, unless prior arrangements have been made.

Signature: ______________________________ Date: ____________________

Medicare Lifetime Authorization

I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediaries or carriers any information needed for this or a related Medicare claim. I request that payment of authorized benefits be made on my behalf. I assign the benefits payable for physician services to the physician or organization furnishing the services or authorize such physician or organization to submit a claim to Medicare for payment.

Signature: ______________________________ Date: ____________________