Countryside Medical Center
3190 McMullen Booth Rd., Ste. 200
Clearwater, FL 33761

Patient Name: First_______________________________________ Last_______________________________________ MI_____

Home Address: ____ City________________________State________Zip______

Birth Date: _____/______/_____ Age: _____ SS # ________-_____-_______ Drivers License # ______________________________

E-mail: ____

Home # (_______)_______________________ Cell # (_______)_____________________ Work # (_______)_____________________

Preferred Contact (CIRCLE): Home Work Cell E-mail

Employer: ____ Occupation: ____

Employer Address:____ Phone # (_______) ______________________

Marital Status: ❑ Single ❑ Married ❑ Partnered ❑ Separated ❑ Divorced ❑ Widowed

Spouse Name: ____ Phone # (_______) ________________________

Employer: ____ Occupation: ____

Emergency Contact:____ Phone # (_______) ________________________

Primary Care Physician: ____ Phone # (_______) ________________________

INSURANCE INFORMATION

Primary Insurance Company Name: ____

Address: ____ Phone: (________) ___________________________

Policy Number: ____ Group Number: ____________________________________

Insured Name: ____ Insured's Date of Birth: ______________________________

Relationship to Insured: ______________________________________ Insured Employer: __________________________________

Secondary Insurance Company Name: ____

Address: ____ Phone: (________) _________________________________

Policy Number: ____ Group Number: ____________________________________

Insured Name: ____ Insured's Date of Birth: ______________________________

Relationship to Insured: ______________________________________ Insured Employer: ____________________________________

Payment/Insurance Authorization and Assignment:

For situations in which I can use my insurance for payment, I hereby authorize Bay Area Women's Care to furnish all information to insurance carriers concerning my illness, and/or treatments, and I hereby assign to the physician all payments for medical services rendered to myself or my dependents. I understand any elective procedures performed by Bay Area Women's Care are not covered by insurance and payment in full is required prior to any surgical procedure.

I understand that I am responsible for any amount not covered by insurance; this includes any course of treatment that is not a covered benefit (this includes HMO products). I understand that I am responsible for notifying Bay Area Women's Care of any changes in my insurance coverage. If I am delinquent in updating this information and the charges are denied, I understand that I will be responsible for these charges.

Patient Name: (please print) ____

Patient's Signature: ____ Date: _____/______/_____