## $\mathcal V$ isalia $\mathcal W$ omen's $\mathcal S$ pecialty $\mathcal M$ edical $\mathcal G$ roup, Inc.

CHART#

	PATIENT INFORMATIO	N CONFIDENT	IAL		
*** PLEASE PRINT ***					
BEST PHONE NO. TO REACH YOU _		CELL PHONE			
BIRTHDATE	SSN/_	/			
PATIENT'S EMPLOYER		WORK PHONE			
BUSINESS ADDRESS		CITY		STATEZIP	
SPOUSE'S NAME	EMPLOYER		_ WORK PHON	E	
PERSON TO CONTACT IN CASE OF	EMERGENCY		PHON	E	
HOW DID YOU FIND OUT ABOUT US	S?				
ANY ALLERGIES? Yes No	IF YES, PLEASE LIST:	and the second second			. 14
	PRIMARY INSURANCI	E INFORMATIO	ON		
	DEL ATION	IOLUD TO DATISHT		1010	
	RELATION				
	EMPLOYER				
	GROUP #				
					Yes 🔲 No
IS THERE ADDITIONAL INSURANCE	COVERAGE?  Yes  No			i:	
	SECONDARY/SUPPLEME	ENTAL INSURA	NCE		
EFFECTIVE DATE	RELATION	ISHIP TO PATIENT _			
	EMPLOYER				
	GROUP #				
INSURANCE COMPANY NAME					
I AUTHORIZE ANY HOLDER OF MEDICAL SERVICES PROVIDED. I AUTHORIZE PAY THIS AUTHORIZATION TO BE USED AS T	L INFORMATION ABOUT ME TO RELEASE INFOR MENT BY MY THIRD PARTY PAYOR DIRECTLY TO THE ORIGINAL.	MATION TO THIRD PART O VISALIA WOMEN'S SPE	Y PAYERS IN ORI CIALTY MEDICAL	DER TO DETERMINE . GROUP, INC. I PERM	BENEFITS FOR MIT A COPY OF
I AUTHORIZE THE PHYSICIANS AND STA EMERGENCY, ANY PATIENT, GUARDIAN AND AGREED TO THE ABOVE CONDITION	AFF OF VISALIA WOMEN'S SPECIALTY MEDICAL WHO REFUSES TO COMPLETE AND SIGN THIS DNS.	GROUP, INC. TO RENDEI AUTHORIZATION FOR TF	R MEDICAL TREA REATMENT MAY E	TMENT, EXCEPT FOI E DENIED SERVICE.	R MEDICAL .I HAVE READ
I verify that the information give	en above is correct.		ş.		
SIGNATURE	DATE	SIGNATURE	AND STREET	DATE	
SIGNATURE	DATE	SIGNATURE		DATE	
SIGNATURE	DATE	SIGNATURE		DATE	
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