Premier Women's Health Center
"Making a difference in women's lives!"
OBGYN offices of:

Bryan Myers, M.D., PC
Melody Harrison, NP-C
Courtney Murray, D.O., P.C.
Mary Beth McClain, APN

Ashley De Witt, D.O., PC
Michael Nobles, M.D., PC
Saharra Jewell, APN

Today's Date:_____

Patient's name:_____
Date of Birth:_____ Age:_____ Social Security #_____
Mailing Address or P.O. Box_____ City_____
State____Zip Code_____ Sex:_____ Home Phone:(___)_____ Cell:(___)_____
Workplace phone:_____ Marital Status:_____
Are you a student?Full time_____ Part time_____ Email_____
Employment_____ Job title_____
Employment status: Full time Part time Not Employed Self Employed Retired Military
Name of Spouse(If you are under 21 name of parent)_____
In case of emergency, who may we notify(other than spouse)?
Name_____ Relationship_____ Phone _____

Insurance Information

Do you have insurance?_____ Name of insurance_____
Subscriber name_____ SS#_____ Date of Birth_____
Your relationship to subscriber_____ Subscriber phone_____
Subscriber mailing address_____
Insurance ID# _____ Group #_____ Employer_____

Secondary insurance/Name of company_____
Subscriber name_____ SS#_____ Date of Birth_____
Your relationship to subscriber_____ Subscriber phone_____
Subscriber mailing address_____
Insurance ID# _____ Group #_____ Employer_____

Who is your primary physician ? _____ Phone_____
Who referred you to our office?_____
Who is responsible for this bill?_____

Premier Women's Health Center
"Making a difference in women's lives!"
OBGYN offices of:

Bryan Myers, M.D., PC
Melody Harrison, NP-C
Courtney Murray, D.O., P.C.
Marv Beth McClain. APN

Ashley De Witt, D.O., PC
Michael Nobles, M.D., PC
Saharra Jewell, APN

I, the undersigned, certify and acknowledge the following:

- I authorize this office to release any health information for the use of treatment, payment, and healthcare operations which include insurance companies, specialists, and other healthcare providers and institutions.
- I am 18 years or older. If you are under 18, your parent or guardian must sign this form.
- I understand that diagnostic tests may be recommended and denial of these tests can result in undiagnosed and untreated health conditions.
- I understand that I am financially responsible for all charges not covered by insurance assignment.
- I assume responsibility for all costs of collections, including financial charge, attorney fees and court costs.
- I have checked and know that my insurance company covers Premier Women's Health Center as a provider in or out of network.
- I understand that medical treatment carries with it some statistical risks even when performed with the utmost care.
- I understand that all co-pays, deductible amounts, or self pay services are due at the time of service.
- I understand that appointment times are reserved specifically for me and that any necessary changes should be finalized two working days prior to the original appointment or a late cancellation fee may be charged.
- I acknowledge I received the Premier Women's Health center privacy notice attached to this form.
- I have accurately answered all the questions here and on the medical history form, and have read all the above information.
- I understand that it is necessary to bring all forms such as disability and FMLA forms in the office one week prior to the time that they are due. I understand that there is a 20.00 fee for these forms.

Signature_____ Date signed_____

Printed name_____

If personal representative signature appears above, please describe authority to do so

_____