Cole Nilson, DO · Rob Sterling, MD · Shelby Coleman, MD.

Obstetrics and Gynecology

PATIENT INFORMATION

LAST NAME		FIRST NAME		M.I.	DATE	
SOCIAL SECURITY NUMBER		DATE OF BIRTH		AGE	MARITAL STATUS	
MAILING ADDRESS				CITY	STATE	ZIP
HOME #	CELL #	PRIMARY CARE PHYSICIAN OR REFERRING PHYSICIAN				
EMPLOYER NAME/ADDRESS		OCCUPATION			BUSINESS PH#	
SPOUSE NAME (PARENT, IF MINOR)		SOCIAL SECURITY NUMBER		CONTACT PH #		
EMERGENCY CONTACT		RELATIONSHIP TO PT	HOME PH #		CELL PH #	
E-MAIL ADDRESS			Mother's Maiden Name			

PRIMARY INSURANCE INFORMATION

POLICY HOLDER'S NAME	DATE OF BIRTH		GROUP/POLICY #		SSN/ID #
PRIMARY INSURANCE COMPANY	RELATIONSHIP TO PT		EMPLOYER'S NAME/ADDRESS/PHONE #		
CLAIMS MAILING ADDRESS	CITY	STATE	ZIP	INSURANCE CO. PHONE #	

I hereby authorize Tulsa Women's Health Care, Inc. to release any medical information necessary to process insurance claims relating to the medical care rendered by Tulsa Women's Health Care, Inc.

Signature ______________________ Date __________

I authorize payments of medical benefits to Tulsa Women's Health Care, Inc. for any medical care rendered to myself or to my dependents. I understand that I am responsible for any amount not covered by my insurance.

Signature ______________________ Date __________