



Moore for Women Healthcare & Wellness
Monica A. Moore, MD

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 Chicago, IL 60611
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1515 E. 52nd Place
 Chicago, IL 60615
 Fax: 312-212-9003

Thank you for choosing our practice! In order to serve you properly, we need the following information.

Please Print. All Information will be confidential.

Today's
Date:

MD: [Redacted] Referring PCP [Redacted]

PATIENT INFORMATION

Patient's Last Name	First	Middle	<input type="checkbox"/> Mr. <input type="checkbox"/> Mrs.	<input type="checkbox"/> Miss <input type="checkbox"/> Ms.	Marital Status <input type="checkbox"/> Sgl <input type="checkbox"/> Mar <input type="checkbox"/> Div <input type="checkbox"/> Sep <input type="checkbox"/> Wid
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Is this your legal name? <input type="checkbox"/> Yes <input type="checkbox"/> No	If not, what is your legal name? (Former/Maiden Name)	Birth Date	Age	Sex <input type="checkbox"/> M <input type="checkbox"/> F
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Street Address/Apt #	City	State	ZIP Code	Social Security	Home Phone No. ()
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P.O. Box	City	State	ZIP Code
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Occupation	Employer	Bus. ()	Cell. ()
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Referring MD/PCP Phone Number	PCP/MD's Address	Patient Dr Lic.St. Id#
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Chose Clinic Because/Referred to Clinic by (Please check one box) Dr. _____ Insurance Plan Hospital
 Family _____ Friend _____ Close to Home/Work Yellow Pages Other _____

Other Family Members Seen Here _____

INSURANCE INFORMATION (PLEASE GIVE YOUR INSURANCE CARDS TO THE RECEPTIONIST)

Person Responsible for Bill-Guarantor	Birth Date	Address (if different)	Business ()
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Is this person a patient here? <input type="checkbox"/> Yes <input type="checkbox"/> No	Mobile/Cell ()
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Occupation	Employer	Employer Address	Employer Phone No. ()
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Is this patient covered by insurance? Yes No

Please indicate primary insurance

Unicare HMO/PPO **RUMC OR NWMH** Aetna HMO/PPO/POS Humana HMO/PPO/EPO BCBS/HMOI **Site#332 only-CHS** United Healthcare HMO/PPO

Medicaid /HFS(children only) Medicare PHCS BCBS PPO/Blue Choice Advantage Other Insurance _____

How much is your deductible? _____ Has it been met? _____
 Max.annual benefit? _____

Guarantor's Name	Guarantor's Social	Guarantor's Drivers	Group #	Policy #	Co-\$
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Patient's Relationship to Subscriber Self Spouse Child Other _____

Name of Secondary Insurance (if applicable)	2nd Subscriber's Name	2nd Subscriber's	Group #	Policy #
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Patient's Relationship to Subscriber Self Spouse Child Other _____

IN CASE OF EMERGENCY

Name of Local Friend or Relative (not living at same address)

Relationship to Patient

Home Phone No.

Work Phone No.

[REDACTED]

[REDACTED]

([REDACTED]) [REDACTED]

([REDACTED]) [REDACTED]

*The above information is true to the best of my knowledge. I authorize my insurance benefits to be paid directly to the physician. I understand that if I do not present all my insurance information at time of service I will be responsible for the entire balance. I understand that I am financially responsible for any balances after insurance has made payment or denied claim. I understand that if after 60 days that my claim is unpaid by my insurance I will be responsible for the balance. I understand that if I am self pay it is my responsibility to make payment arrangements before I leave the office or the entire balance will be due in 30 days after my date of service. I also authorize Woman to Woman Healthcare & Wellness to advise and or to release any information concerning my (my child's) healthcare that is required to process my claims. I understand that my Social Security Number is use for insurance purposes only and is protected under the guidelines of HIPPA. I am authorizing evaluation of my health and treatment to the above listed physician and I have read and understand Woman to Woman Healthcare & Wellness Notice of Privacy Practices.
Update 12/07*

Patient/Guardian-Guarantor/Subscriber' Signature

[REDACTED]

Date

[REDACTED]