FATEH HRAKY, MD
HOWARD POPKIN, MD
DENNIS STERN, MD

LAST NAME: ______________________________ FIRST NAME: ________________________ MI: _____

STREET ADDRESS: ______________________________________________________________________

CITY: ________________________________ STATE: ________________________ ZIP: _____________

SSN: __________________________________ DATE OF BIRTH: _________________________________

PHONE: ________________________________ ALTERNATE: _____________________________________

EMAIL ADDRESS: _____________________________ MARITIAL STATUS: __________________________

PHARMACY INFORMATION (NAME, ADDRESS, PHONE):

______________________________________________________________________________________

EMERGENCY CONTACT (NAME AND PHONE NUMBER):

______________________________________________________________________________________

NAME OF INSURANCE COMPANY: _____________________________________________________________

POLICY NUMBER: _________________________________ GROUP NUMBER: _______________________

SECONDARY INSURANCE COMPANY: ___________________________________________________________

POLICY NUMBER: _________________________________ GROUP NUMBER: _______________________

______________________________________________________________________________________

**FINANCIAL REPSONSIBILITY:**

**I AUTHORIZE PAYMENT OF MEDICAL BENEFITS TO BAY WOMEN'S HEALTH FOR PROFESSIONAL SERVICES RENDERED AND THE RELEASE OF MEDICAL INFORMATION NECESSARY TO PROCESS CLAIMS FOR SERVICES RENDERED.**

**I UNDERSTAND THAT I AM RESPOSIBLE FOR ALL COPAYS, DEDUCTIBLES, AND NON-PAYMENTS FROM MY INSURANCE COMPANY. I AM AWARE THAT IF I AM SEEN FOR A PROBLEM VISIT THAT I AM RESPONSIBLE TO PAY THE COPAY/DEDUCTIBLE AT THE TIME OF MY VISIT. FUTHERMORE, I UNDERSTAND IF I AM SEEN FOR MY WELL WOMAN CHECK-UP AND PROBLEMS ARE FOUND AT THAT TIME, THAT I MAY BE SUBJECT TO A COPAY.**

SIGNATURE: ________________________________ DATE: ________________________________