MEXICO WOMEN'S HEALTH SPECIALISTS
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Michael D. Jones, M.D.F.A.C.O.G. **Carla Price, F.N.P.-B.C.**

NAME:_____ MARITAL STATUS: M S W D
Last First Middle (Circle One) Separated

MAILING ADDRESS_____ CITY_____ STATE_____ ZIP_____

DATE OF BIRTH_____ SS#_____ TELEPHONE_____

EMAIL ADDRESS:_____ CELL# _____

EMPLOYER_____ OCCUPATION_____

EMPLOYER'S ADDRESS_____ EMPLOYER'S TELEPHONE_____

HUSBAND'S NAME_____ DATE OF BIRTH_____ SS#_____

EMPLOYER_____ OCCUPATION_____

EMPLOYER'S ADDRESS_____ EMPLOYER'S TELEPHONE_____

NEAREST FRIEND OR RELATIVE **NOT** RESIDING WITH YOU_____

RELATIONSHIP_____ TELEPHONE(HOME)_____ (WORK)_____

(CELL)_____

MEDICATION ALLERGIES_____

REFERRED BY DR:_____ PRIMARY DR_____

PRIMARY INSURANCE_____ SECONDARY INSURANCE_____

SUBSCRIBER_____ SUBSCRIBER_____

POLICY #_____ POLICY#_____

GROUP#_____ GROUP#_____

SIGNATURE ON FILE:
I AUTHORIZE RELEASE OF INFORMATION TO ALL MY INSURANCE COMPANIES. I AUTHORIZE THE USE OF THIS FORM ON ALL MY INSURANCE SUBMISSIONS. I AUTHORIZE MY PHYSICIAN TO ACT AS MY AGENT IN HELPING ME OBTAIN PAYMENT FROM MY INSURANCE COMPANIES. I AUTHORIZE PAYMENT DIRECTLY TO MY PHYSICIAN. I UNDERSTAND THAT I AM RESPONSIBLE FOR MY BILL FOR ANY AND ALL SERVICES. I AUTHORIZE THE RELEASE OF ANY MEDICAL INFORMATION TO REFERRING PHYSICIANS CONCERNING MY ILLINESS AND TREATMENTS.

SHOULD THIS ACCOUNT BECOME DELINQUENT THE UNDERSIGNED AGREES TO PAY ALL OF COLLECTOR'S COLLECTION EXPENSES, INCLUDING ALL COLLECTION AGENCY FEES AND ALL ATTORNEY FEES. IF SUIT IS BROUGHT, IT MAY BE FILLED IN THE COUNTY WHERE SERVICES WERE RENDERED.

SIGNATURE_____ DATE_____

(PRINT NAME)_____