Chicago Women's Health, Ltd

Eden Takhsh, MD Elizabeth Torres, APN

Patient Information Sheet

Name of Patient________________________ Age_______ Date of Birth________________

Marital Status: ❒Married ❒Single ❒Divorced ❒Widowed

Address________________________ Social Security#________________________

City/State/Zip____

Home Phone________________________ Work Phone________________________

Occupation________________________ Referring Dr________________________

Employer________________________ Responsible Party Name________________________

Employer's Address________________________ Resp. Party Address________________________

City/State/Zip________________________ City/State/Zip________________________

Email address________________________ (We may contact you on occasion via email for reminders & office news. We will not transmit protected or personal health information without express written consent.)

Emergency Contact/Relationship/Phone____

Insurance Information

Primary________________________ Secondary________________________

Insured's Name________________________ Insured's Name________________________

Insured's Birthdate:________________________ Insured's Birthdate:________________________

Group #________________________ Group #________________________

ID #________________________ ID #________________________

Ins Type: ❒PVT❒PPO❒HMO❒POS Ins Type: ❒PVT❒PPO❒HMO❒POS

Address________________________ Address________________________

City/State/Zip________________________ City/State/Zip________________________

Medicare #________________________ Public Aid________________________

Copay ❒Yes ❒No Amount________________________

Referral ❒Yes ❒No Did you bring your Referral ? ❒Yes ❒No

I hereby authorize Chicago Women's Health, Ltd to release any information to my insurance company acquired in the course of my examination or treatment. I hereby authorize benefits to be paid directly to Eden Takhsh, MD. I understand that I am responsible for any unpaid balance.

Signed________________________ **Date**________________________