Athena Health and Wellness
A Center for Women

PATIENT INFORMATION FORM

Patient Full Name:	Marital Status: Married Single Widow Divorced
Preferred Name: Preferred pronoun(s):	Race: Ethnicity:
Date of Birth:	Social Security Number:
Address (including: city, state, & zip code): Is it okay to send mail to your home? (circle) YES / no	Home phone: Is it okay to call you? (circle) YES / no
Cell Phone: Is it okay to call and text this number? (circle) YES / no	Email address: May we add you to our E-mail list? (circle) YES / no
Employer:	Occupation:
Spouse's/partner's/guardian's name:	Spouse/partner/guardian phone number:
Emergency Contact:	Emergency contact phone number:
How did you hear about our center?	May we access your medication history? YES / no
Primary care/referring provider:	Preferred pharmacy:
PRIMARY INSURANCE INFORMATION	SECONDARY INSURANCE INFORMATION
Insurance Plan	Insurance Plan
Identification Number	Identification Number
Group Number	Group Number
Subscriber Subscriber date of birth:	Subscriber Subscriber date of birth:
I authorize release of information to the following: Self Only Spouse/partner Guardian Other:_____	I give permission to contact me or leave messages communications regarding upcoming appointments / test results / medical information: Home Cell Text E-mail

********** PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE **********

I CERTIFY THAT THE INFORMATION I HAVE REPORTED HEREIN IS CORRECT. I AUTHORIZE THE RELEASE OF ANY INFORMATION NECESSARY IN ORDER TO PROCESS INSURANCE CLAIMS AND DO ASSIGN TO ATHENA HEALTH AND WELLNESS, LLC ALL MONIES TO WHICH THEY ARE ENTITLED FOR MEDICAL AND/OR SURGICAL EXPENSES RELATED TO THIS CARE. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES NOT PAID BY MY INSURANCE COMPANY AND THAT OUTSTANDING BALANCES NOT PAID BY MY INSURANCE CARRIER AFTER 90 DAYS WILL BE DUE AND PAYABLE IN FULL BY ME AT THAT TIME. IN ADDITION, I AM RESPONSIBLE FOR ANY CHARGES INCURRED TO COLLECT ON OVERDUE ACCOUNTS AND INTEREST MAY BE CHARGED ON OUTSTANDING BALANCES. THE DIAGNOSTIC LABORATORY OF RECORD IS QUEST DIAGNOSTICS. I UNDERSTAND THAT IF I DO NOT INFORM ATHENA HEALTH AND WELLNESS, LLC THAT MY DIAGNOSTIC LABORATORY WORK MUST BE SENT TO ANY OTHER LABORATORY, I WILL BE FINANCIALLY RESPONSIBLE IN THE ENTIRETY FOR ALL LAB SERVICES PERFORMED ON MY BEHALF IF NOT COVERED BY MY INSURANCE PLAN.

Date ____/____/_____ Patient Signature: _____