About Women's Health Medical Group
Catherine Grellet, M.D.

Date ______________________ Account # __________

Patient Name ______________________________________ SS# ____________________

Date of Birth ______________ Age ________ Home Phone# ____________________

Address ________________________________ City ____________________ ZIP ________

Occupation ____________________ Employer ________________________________

Address ____ Business Phone ______________

Cell # ______________ Home FAX ____________________ Marital Status M W S D SO

Name of Spouse/SO/Guardian/Parent ________________ Address ____________________

Home# ______________ Employer ______________ Bus. Phone# ____________________

Bus. Address ________________________________ Cell # ____________________

Referred by: ____________________ Preferred Pharmacy with Phone # ____________________

Name of Friend/Relative not living with you ______________________ Phone# ______________

In case of emergency Contact ______________________________ Phone# ______________

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IINSURANCE INFORMATION (please give us your card to copy also)

Primary Ins. Co. Name ______________________ Secondary Ins.Co ______________________

Billing Add. ______________________ Billing Add. ______________________

Insured's Name ______________________ Insured's Name ______________________

Cert/Member# ______________________ Cert/Member# ______________________

Group/Policy# ______________________ Group/Policy# ______________________

Union Local# ______________________ Union Local# ______________________

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Financial Responsibility and Assignment of Benefits Policy:
I hereby agree to pay my account as SERVICES ARE PROVIDED. I agree that in event of hospitalization. I will assign all medical benefits including major medical benefits to Dr. Grellet. I authorize release of any necessary medical information to complete my claim. I also agree to be responsible for my labs and X-rays ordered at outside facilities.

Signed ____ Date ______________