Taguchi Women's Clinic, PLLC

801 S. Walnut
Stillwater, OK 74074
(405)372-6246

PERSONAL INFORMATION

Name: ____
Last First Middle

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed Sex: ☐ Male ☐ Female

Date of Birth: _______/_______/_______ Social Security #: _______-_______-_______

Street Address: ________________________________ (Apt #)_____City:________________ State:_____ Zip:_________

Home Phone: (_____)________________ Work Phone: (_____)________________

Employer/School:____ ☐ Full-Time ☐ Part Time

Spouse's Name: ____ Spouse's Work Phone: (_____)___________________

Spouse's Social Security #: _______-_______-________ Spouse's Date of Birth: ______/______/______

Spouse's Employer: ____

Guarantor (if other than patient):_________________________________ Guarantor's Home Phone: (____)__________

Guarantor's Address: ____ City:____________ State:________ Zip:_______

Guarantor's Social Security#: _______-_______-_______ Guarantor's Work Phone: (___)___________________

INSURANCE INFORMATION

Please present Insurance Card(s) to Receptionist

PRIMARY Insurance Company:____

Name of Insured:__________________________________SS#: _______-_______-_______ Date of Birth: ____/____/_____

Street Address: ________________________________ (Apt #)______City:________________ State:_____Zip:_________

Insured's Employer:__________________________________ Insurance ID#:_________________Group #:_____________

Patient Relationship to Insured:_________________________________ Insured's Work Phone: (____)_______________

SECONDARY Insurance Company:____

Name of Insured:__________________________________ SS#:______-______-_______ Date of Birth:____/____/______

Street Address: ________________________________ (Apt #)_______City:________________ State:____ Zip:_________

Insured's Employer:__________________________________ Insurance ID#:__________________ Group #:___________

Patient Relationship to Insured:_________________________________ Insured's Work Phone: (____)_______________

EMERGENCY CONTACT

Name:____ Relationship:______________________

Street Address: _____________________________________ (Apt #)______ City:________________ State:_______ Zip:__________

Home Phone: (_____)________________________ Work Phone: (____)________________________

ASSIGNMENT OF BENEFITS

I understand that I am financially responsible for all charges whether or not they are covered by my insurance. I hereby give authorization for payment of insurance benefits to be made directly to Taguchi Women's Clinic, PLLC and any assisting providers, for services rendered. I hereby authorize Taguchi Women's Clinic, PLLC to release all information necessary to secure the payment of benefits. I further agree that a photocopy of this agreement shall be as valid as the original.

Signature:____ Date:________________