



Avera Doctors Plaza 1
 1001 East 21st Street, Suite 401
 Sioux Falls, SD 57105
 (605) 322-8920

Patient Information

- | | | | | |
|---|--|---|--|---|
| <input type="checkbox"/> Jane Gaetze, MD | <input type="checkbox"/> Amal Salama, DO | <input type="checkbox"/> Jane Peters, MD | <input type="checkbox"/> Teri Vander Stouwe, CNM | <input type="checkbox"/> Naomi Wahl, MD |
| <input type="checkbox"/> Patricia Wirtz, MD | <input type="checkbox"/> Jodi Scott, MD | <input type="checkbox"/> Danielle Berdahl, MD | <input type="checkbox"/> Lisa Van Gerpen, CNM | <input type="checkbox"/> Les Heddleston, MD |
| | | | | <input type="checkbox"/> Imaging Center |

Name: _____
Legal Last Name First MI

Mailing Address: _____
Street PO Box or Apt # City State Zip

Date of Birth: _____ Social Security #: _____

Phone # (H): _____ Phone # (W): _____ Cell #: _____

Patient's Employer: _____ Referring Physician: _____

Sex: Male Female Pregnant: Yes No Marital Status (Married, Single, Divorced, Other) _____

Primary Insurance: _____ Eff Date: _____

Policy Holder: _____ Relationship to Patient: _____

Policy #: _____ SS # of Policy Holder: _____ Group #: _____

Employer of Policy Holder: _____ Date of Birth for Policy Holder: _____

Secondary Insurance: _____ Eff Date: _____

Policy Holder: _____ Relationship to Patient: _____

Policy #: _____ SS # of Policy Holder: _____ Group #: _____

Employer of Policy Holder: _____ Date of Birth for Policy Holder: _____

Person to Notify in Case of Emergency: Name _____ Relationship _____

Cell Phone #: _____ Home #: _____ Work #: _____

Avera Women's Specialty Clinics may share medical and/or billing information with the following individuals who are involved with the patient's care.

Release to: _____ Relationship: _____

Release to: _____ Relationship: _____

Patient/Parent/Guardian Signature: _____

_____ Date: _____

(This remains in effect until further notification from patient/parent/guardian.)

Authorization for care & treatment:

The undersigned hereby grants authorization for treatment & procedures for the patient by physicians, members of the staff, and employees of Avera Women's Specialty Clinics.

I request payment of authorized benefits be made on my behalf to Avera Women's Specialty Clinics for any services furnished me by Avera Women's Specialty Clinics. I authorize my holder of medical information to release to insurance carriers any information needed to determine benefits payable for services provided. I understand that I am responsible for any charges not covered by insurance. I authorize Avera Women's Specialty Clinics to release necessary information and medical records only as required to assure continuity of care with other health care providers, for reimbursement or for accreditation purposes.

Signed: _____ Date: _____

Or/By: _____ Relationship to Patient: _____