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## PATIENT INFORMATION

Date \_\_\_\_\_  
Name \_\_\_\_\_  
Last First Middle  
Date of Birth \_\_\_/\_\_\_/\_\_\_ Age \_\_\_  Single  Married  Divorced  Other \_\_\_\_\_  
Address \_\_\_\_\_  
Street City State Zip  
Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ Ext \_\_\_\_\_  
Pager \_\_\_\_\_ Cell \_\_\_\_\_  
Employer \_\_\_\_\_ Social Security # \_\_\_\_\_  
Name of Primary Care Doctor \_\_\_\_\_ Phone # \_\_\_\_\_

Spouse  Parent \_\_\_\_\_ Social Security # \_\_\_\_\_  
Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_  
Emergency Contact (other than above) \_\_\_\_\_ Phone # \_\_\_\_\_  
Who may we thank for referring you? \_\_\_\_\_

**YOU WILL BE EXPECTED TO PAY FOR YOUR VISIT IN FULL TODAY,  
UNLESS YOU HAVE A PPO OR HMO INSURANCE THAT WE PARTICIPATE WITH.**

## INSURANCE INFORMATION (must be complete)

Primary Insurance \_\_\_\_\_ Policy # \_\_\_\_\_ Group # \_\_\_\_\_  
Policy Holder (Employee) \_\_\_\_\_ Date of Birth \_\_\_/\_\_\_/\_\_\_ SS # \_\_\_\_\_  
 Self  Spouse  Parent  
Employer \_\_\_\_\_

Secondary Insurance \_\_\_\_\_ Policy # \_\_\_\_\_ Group # \_\_\_\_\_  
Policy Holder (Employee) \_\_\_\_\_ Date of Birth \_\_\_/\_\_\_/\_\_\_ SS # \_\_\_\_\_  
 Self  Spouse  Parent  
Employer \_\_\_\_\_

I hereby authorize the physicians whose names appear on this statement to release any information acquired in the course of examination or treatment, and allow a photocopy of my signature to be used for insurance purposes only. I also authorize payment of benefits due to me, to be made directly to the physicians named on this statement. I understand that I am financially responsible for these charges.

Policy Holder or Insured Person  \_\_\_\_\_

# PHONE MESSAGE CONSENT FORM

From time to time, in caring for our patients, it may be necessary or desirable to contact our patients by phone. When a patient is not available to speak directly, we may possibly need to leave messages.

In order to protect your privacy, we have developed this policy on leaving messages:

- We will not leave messages with anyone except the patient or legal guardian.
- We will not leave any patient information on an answering machine.
- We will not leave any patient message on a voicemail system.

## UNLESS

You give your written permission to leave messages for you. Please read the information below and carefully consider to whom you want information given. Medical information includes labs, ultrasounds, and any other test results, as well as appointment times. Also to include any business office concerns.

I, \_\_\_\_\_ give Women's Associates staff my permission to leave phone messages regarding my medical care with the following. This consent will remain in effect until otherwise noted in writing.

### Please print phone numbers and names

My home phone answering machine number (\_\_\_\_\_) \_\_\_\_\_

My office phone voice mail number (\_\_\_\_\_) \_\_\_\_\_

My cell phone voice mail number (\_\_\_\_\_) \_\_\_\_\_

My spouse or other family members names and numbers that I give permission to leave a message with:

Name \_\_\_\_\_ Phone number (\_\_\_\_\_) \_\_\_\_\_

I also give Women's Associates permission to give medical information to my Primary Care Physician:

Name \_\_\_\_\_ Phone number (\_\_\_\_\_) \_\_\_\_\_

Other \_\_\_\_\_ Phone number (\_\_\_\_\_) \_\_\_\_\_

Signature \_\_\_\_\_ Date \_\_\_\_\_