

Pamela K. Richards, M.D.  
Jill A. Murray, M.D.  
Deborah S. Lasley, M.D.  
Jennifer L. Even, M.D.  
Lisa M. Hovenga, M.D.

Women's Associates, P.C.  
1015 E. Pikes Peak Ave  
Suite 100  
Colorado Springs, CO 80903  
(719) 473-2424

## 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 or Parent (circle one) \_\_\_\_\_ 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 me to be made directly to the physicians named on this statement. I understand that I am financially responsible for these charges.

X \_\_\_\_\_

Policy Holder or Insured Person