WOMEN'S HEALTH TODAY

Providence Professional Plaza
5050 N.E. Hoyt, Suite 421
Portland, Oregon 97213
(503) 239-6800

Maxine Bauer, M.D.	
Desiree Bley, M.D.	
Janet Gibbens, M.D.	
Nancy Grant, M.D.	
Oscar Polo, M.D.	
Liana Corliss, F.N.P.	
Karen Parker Linn, C.N.M.	

ACCOUNT NUMBER	DATE / /	**PRIMARY CARE PHYSICIAN**

PATIENT CHANGE OF INFORMATION FORM - *(Please Print)*

PATIENT'S LAST NAME	FIRST NAME	MIDDLE NAME	BIRTHDATE
PATIENT'S ADDRESS		S.S. #	
CITY	STATE	ZIP CODE	PATIENT'S PHONE
MESSAGE PHONE	PATIENT'S EMPLOYER	EMPLOYER PHONE NUMBER	OCCUPATION

PERSONAL INSURANCE INFORMATION - PRIMARY

Insurance Co. ______________________

Address ______________________

Group # __________ I.D. # ______________________

Subscriber ______________________

Subscriber Date of Birth ______________________

Employer ______________________

Relationship ______________________

SECONDARY INSURANCE

Insurance Co. ______________________

Address ______________________

Group # __________ I.D. # ______________________

Subscriber ______________________

Subscriber Date of Birth ______________________

Employer ______________________

Relationship ______________________

NAME OF FRIEND OR RELATIVE OR GUARDIAN OR PARENT - NOT LIVING WITH YOU (FOR MEDICAL EMERGENCY)

Name ______________________ Relationship ______________ Phone ______________

****** AUTHORIZATION FOR RELEASE OF INFORMATION & ASSIGNMENT OF BENEFITS ******

I authorize payment of medical benefits to Maxine Bauer, M.D., Desiree Bley, M.D., Janet Gibbens, M.D., Nancy Grant, M.D., Oscar Polo, M.D., Karen Parker Linn, C.N.M and/or Liana Corliss, F.N.P. I also authorize the release of any medical information necessary to process this claim. I understand that I am financially responsible to Women's Health Today for charges not covered by my insurance plan.

______________________ SIGNATURE

______________________ DATE