Taguchi Women's Clinic, PLLC

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

PERSONAL INFORMATION

Name _____ (Last) _____ (First Name) _____ (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 Employer: _____ Spouse's Date of Birth: __/__/__

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: _____ Insured's SS#: ___-___-____ Insured's Date of Birth: __/__/__

Street Address _____ (Apt #)_____ City _____ State _____ Zip _____

Insured's Employer: _____ Insurance ID#: _____ Group #: _____

Patient Relationship to Insured: _____ Insured's Work Phone: (___)_____

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SECONDARY Insurance Company: _____

Name of Insured: _____ Insured's SS#: ___-___-____ Insured's 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: _____