Capital Womens Care
8110 Maple Lawn Boulevard, Suite 235
Fulton, MD 20759-2693
USA
(800) 924-0066

CAPITAL WOMEN'S CARE

PATIENT INFORMATION

NAME (Last, First/Preferred Middle)	MRN	SSN#	BIRTHDATE	LANGUAGE	SEX

LOCAL ADDRESS	CITY, STATE ZIP	REFERRING PHYSICIAN	SECONDARY/BILLING ADDRESS	ETHNICITY

HOME PHONE	DAY PHONE	EMAIL ADDRESS	PRIMARY CARE PROVIDER	CITY, STATE ZIP	RACE

MARITAL STATUS	STUDENT STATUS ☐ Full-Time ☐ Part-Time	SMOKER (Y/N)?	VETERAN (Y/N)?	EMERGENCY CONTACT NAME	CONTACT PHONE	HOME PHONE

SEXUAL ORIENTATION	PREFERRED PRONOUN	GENDER IDENTITY	CURRENT GENDER	

PRIMARY EMPLOYER	SECONDARY EMPLOYER (if Applicable)
ADDRESS	ADDRESS
CITY, STATE ZIP	CITY, STATE ZIP
WORK PHONE	WORK PHONE

RESPONSIBLE PARTY INFORMATION (if Different than above)

NAME (Last, First Middle)	SSN#	BIRTHDATE	LANGUAGE	SEX

LOCAL ADDRESS	CITY, STATE ZIP	SECONDARY/BILLING ADDRESS (if Applicable)

HOME PHONE	DAY PHONE	EMAIL ADDRESS	CITY, STATE ZIP

MARITAL STATUS	STUDENT STATUS ☐ Full-time ☐ Part-time	SMOKER (Y/N)?	VETERAN (Y/N)?	PRIMARY CARE PROVIDER	HOME PHONE

RELATIONSHIP TO PATIENT	

PRIMARY INSURANCE

NAME OF INSURANCE COMPANY		POLICY#	
NAME OF INSURED		GROUP#	
ADDRESS OF INSURANCE COMPANY		COPAY AMT $	
CITY, STATE ZIP	PHONE	DEDUCTIBLE $	
RELATIONSHIP TO PATIENT		EFFECTIVE DATE	EXPIRATION DATE

SECONDARY INSURANCE (if Applicable)

NAME OF INSURANCE COMPANY			POLICY#	
NAME OF INSURED	SSN#	BIRTHDATE	GROUP#	
ADDRESS OF INSURANCE COMPANY			COPAY AMT $	
CITY, STATE ZIP	PHONE		DEDUCTIBLE $	
RELATIONSHIP TO PATIENT			EFFECTIVE DATE	EXPIRATION DATE

I certify that the information I have provided is correct and I authorize Capital Women's Care to verify insurance coverage and benefits allowed in accordance with my insurance plan's coverage I authorize payments be made directly to Capital Women's Care for all medical insurance benefits which are payable under the terms of my insurance policy for services provided.I agree to pay any copayment, coinsurance, or deductible as required by my insurance for services provided to me or my dependent. I understand that I am responsible for knowing the terms of my insurance plan. Capital Women's Care may impose a no-show fee of $35 for appointments not canceled 24-hours in advance. ~~Reasonable interest, late charges and direct collection costs[25%]and/or legal fees may be imposed. There is a $40 fee on returned checks.~~

SIGNATURE OF PATIENT/GUARDIAN DATE