



**Women's Health For Life, Inc.**

1005 Bellefontaine Ave., Suite 175  
 Lima, OH 45804  
 Phone (419) 227-2727  
 Fax (419) 227-2737  
[www.womenshealthforlife.com](http://www.womenshealthforlife.com)

770 West High Street, Suite 400  
 Lima, OH 45801

**PATIENT INFORMATION SHEET**

Ms/Mrs. Circle One		First Name		MI	Last Name		
Address				City		State	Zip
Home Telephone		Cell Phone		Date of Birth		Spouse's Name	
Social Security Number				Pharmacy & Address			
Referred By			Primary Care Physician		City	Phone	
Marital Status <b>Single / Married</b>			Does your insurance require a referral? <b>Yes / No</b>			Did you obtain the referral? <b>Yes / No</b>	
Emergency Contact & Relationship				Emergency Contact Phone Number (not home number)			
Employed By (Patient)				Work Telephone Number		Ext	
Address of Employer				City		State	Zip
Primary Insurance Plan				Social Security Number of Policy Holder			
Policy Number		Group Number			Expiration Date		
Name of Policy Holder		Date of Birth			Relation to Insured		
Address				City		State	Zip
Telephone Number		Employer of Policy Holder			Employer Phone		
Secondary Insurance Plan				Social Security Number of Policy Holder			
Policy Number		Group Number			Expiration Date		
Name of Policy Holder		Date of Birth			Relation to Insured		
Address				City		State	Zip
Telephone Number		Employer of Policy Holder			Employer Phone		
<p><b>PLEASE READ AND SIGN THE FOLLOWING: Thank You</b>          Authorization for Treatment: I authorize Women's Health for Life, Inc. and its staff to provide routine examinations, diagnostic tests, procedures and treatments as deemed necessary. By signing, I give consent for the above and I understand that this consent will remain in effect until I withdraw it in writing.</p>							
Signature				Parent of Guardian Signature (if Minor)			
Date				Witness			