Fill forms and return ASAP.
Appointment will be canceled if forms are not received one week before appt. date. Missed appointments will not be rescheduled.

Progressive Women's Health, P.A.

Michael J. Coyle, D.O.

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Milton, FL 32570 *Fax: (850) 983-3546*

Welcome To Our Office *Date:* ____________________

Patient Name: (Last) ____________________ (First) ____________________ (MI) __________

Physical Address: ________________________(City) ____________ (State) _____ (Zip) _______

Mailing Address: (if different from above) ____

Email Address: ____

Phone: ( ) ________________ Cell Phone: ( ) _________________ Date of Birth: ___________

Social Security #: _______________________ Race: ________________ Sex: Male Female

Martial Status: Married ( ) Single ( ) Divorced ( ) Widowed ( ) Separated ( )

Patient's Employment Information:

Employer's Name: ____ Phone: ______________

Address: ______________________________ (City) ____________ (State) _____ (Zip) _______

If under the age of 18 years,

Parent/Guardian: ____ Date of Birth: ___________

Phone: ( ) ____________________ Work Phone: ( ) _______________ Sex: _____ Race: _____

Social Security Number: ___________________________ Relationship to Patient: ______________

Insurance Information:

First Insurance: _______________________ Policyholder's Name: _______________ DOB: ______

Social Security #: _____________________ Insurance ID #: _______________ Grp#___________

Insured's Employer: ____

Second Insurance: _____________________ Policyholder's Name: _______________ DOB: ______

Social Security #: _____________________ Insurance ID #: _______________ Grp#___________

Insured's Employer: ____

Release of Information: The Physician may disclose all or any of the patient's records to any person or corporation which is or maybe liable under contract to the Physician or the partner or to a family member or employer of the patient, for all or part of the physician charges, including but not limited to insurance companies, worker's compensation carriers and welfare funds. The Physician may also send copies of all or part of the patient's records to any Physician that participates in the total medical care of the patient.

Assignment of Insurance Benefits: In the event the patient is entitled to Physician benefits arising out of any policy of insurance insuring the patient or any other party liable to patient, said benefits are hereby assigned to the Physician for application on patient's bill and it is agreed the Physician upon receipt of such benefits, shall discharge said insurance company of any and all obligations under the policy to the extent of such payment and the undersigned and/oir the patient shall be responsible for all charges not covered by this assignment.

Medicare/Medicaid Patients Certification: I hereby certify that the information given by me in applying for payment under Titles XVIII & XIX of the Social Security Act is correct. I authorize the release of all my medical records required to act on this request and that payment of authorized benefits be made directly to the Physician(s) involved in my care for any services furnished to me by said Physician.

Please remember that insurance is considered a method of reimbursing the patient for fees paid to the doctor and is not a substitute for payment. Some companies pay fixed allowances for certain procedures and others pay a percentage of the charge. I understand it is my responsibility to pay any deductible amount, co-insurance, or any other balance not paid by my insurance or third party payer within a reasonable amount of time not to exceed (60) days. If this account is assigned to collection and/or suit, the prevailing party shall be entitled to reasonable attorney's fees and costs of collection.

Signature: ____ Dated: ______________________