



Providence Professional Plaza
 5050 N.E. Hoyt, Suite 362
 Portland, Oregon 97213
 503-239-6800

Maxine Bauer, M.D.	
Desiree Bley, M.D.	
Anika Denali Luengo, M.D.	
Janet Gibbens, M.D.	
Nancy Grant, M.D.	
Oscar Polo, M.D.	
Liana Corliss, F.N.P.	
Hannah Litt, 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
BEST DAYTIME PHONE #	PATIENT'S EMPLOYER		EMPLOYER PHONE NUMBER	OCCUPATION	
PREFERRED PHARMACY NAME		PHARMACY PHONE NUMBER		PERSONAL EMAIL ADDRESS	
MARITAL STATUS	DRIVER'S LICENSE #	RACE/ETHNICITY		HOW DID YOU HEAR ABOUT US?	

PERSONAL INSURANCE INFORMATION - PRIMARY

Subscriber _____
 Insurance Co. _____ Subscriber Date of Birth _____
 Address _____ Employer _____
 Group # _____ ID # _____ Relationship _____

SECONDARY INSURANCE

Subscriber _____
 Insurance Co. _____ Subscriber Date of Birth _____
 Address _____ Employer _____
 Group # _____ ID # _____ 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., Anika Denali Luengo, M.D., Janet Gibbens, M.D., Nancy Grant, M.D., Oscar Polo, M.D., Liana Corliss, F.N.P., and/or Hannah Litt, C.N.M. 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 _____