



Avera Doctors Plaza 1  
1001 East 21st Street  
Sioux Falls, SD 57105  
(605) 322-8920

Member of Avera Medical Group

# Patient Information

|  |   |   |   |  |
|--|---|---|---|--|
| <b>1st floor-Urogynecology</b><br>Matthew Barker, MD | <b>1st floor-Maternal Fetal Medicine</b><br>Maria Palmquist, MD<br>Naomi Wahl, MD<br>Les Heddlston, MD<br>Nicole Rose, MS | <b>2nd floor-OBGYN</b><br>Yvonne Seger, MD<br>Kimberlee McKay, MD<br>Brenda Kallemeyn, MD<br>Danielle Berdahl, MD | <b>4th floor-OBGYN &amp; CNM</b><br>Jane Peters, MD<br>Patricia Wirtz, MD<br>Jane Gaetze, MD<br>Molly Uhing, MD | Amal Salama, DO<br>Jodi Scott, MD<br>Lisa Van Gerpen, CNM<br>Teri Vander Stouwe, CNM |
|--|---|---|---|--|

Name: \_\_\_\_\_  
Legal Last Name First MI

Mailing Address: \_\_\_\_\_  
Street PO Box or Apt # City State Zip

Date of Birth: \_\_\_\_\_ Social Security #: \_\_\_\_\_

Phone # (H): \_\_\_\_\_ Phone # (W): \_\_\_\_\_ Cell #: \_\_\_\_\_

Patient's Employer: \_\_\_\_\_ Referring Physician: \_\_\_\_\_

Sex:  Male  Female Pregnant:  Yes  No Marital Status (Married, Single, Divorced, Other) \_\_\_\_\_

**Primary Insurance:** \_\_\_\_\_ Eff Date: \_\_\_\_\_

Policy Holder: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

Policy #: \_\_\_\_\_ SS # of Policy Holder: \_\_\_\_\_ Group #: \_\_\_\_\_

Employer of Policy Holder: \_\_\_\_\_ Date of Birth for Policy Holder: \_\_\_\_\_

**Secondary Insurance:** \_\_\_\_\_ Eff Date: \_\_\_\_\_

Policy Holder: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

Policy #: \_\_\_\_\_ SS # of Policy Holder: \_\_\_\_\_ Group #: \_\_\_\_\_

Employer of Policy Holder: \_\_\_\_\_ Date of Birth for Policy Holder: \_\_\_\_\_

**Person to Notify in Case of Emergency:** Name \_\_\_\_\_ Relationship \_\_\_\_\_

Cell Phone #: \_\_\_\_\_ Home #: \_\_\_\_\_ Work #: \_\_\_\_\_

Avera Women's may share medical and/or billing information with the following individuals (excluding physicians) who are involved with the patient's care.

Release to: \_\_\_\_\_ Relationship: \_\_\_\_\_

Release to: \_\_\_\_\_ Relationship: \_\_\_\_\_

Patient/Parent/Guardian Signature: \_\_\_\_\_

Date: \_\_\_\_\_

(This remains in effect until further notification from patient/parent/guardian.)

Authorization for care & treatment:

The undersigned hereby grants authorization for treatment & procedures for the patient by physicians, members of the staff, and employees of Avera Women's Specialty Clinics.

I request payment of authorized benefits be made on my behalf to Avera Women's Specialty Clinics for any services furnished me by Avera Women's Specialty Clinics. I authorize my holder of medical information to release to insurance carriers any information needed to determine benefits payable for services provided. I understand that I am responsible for any charges not covered by insurance. I authorize Avera Women's Specialty Clinics to release necessary information and medical records only as required to assure continuity of care with other health care providers, for reimbursement or for accreditation purposes.

Signed: \_\_\_\_\_ Date: \_\_\_\_\_

Or/By: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_