ASSOCIATES IN women's health

PATIENT DATA SHEET

Name: _____

Birth Date: _____ Social Security Number: _____

Marital Status: Single Married Separated Divorced Widowed Life Partner

Race: _____ Ethnicity: _____ Preferred Language: _____

Country of Origin: _____

Patient's Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Patient's Employer: _____ Position: _____

Email Address: _____

Name of Primary Insurance: _____

Subscriber's Name: _____

Social Security Number: _____ Birth Date: _____

Relationship to Patient: _____ Policy Effective Date: _____

ID # _____ Group # _____

Name of Secondary Insurance: _____

Subscriber's Name: _____

Social Security Number: _____ Birth Date: _____

Relationship to Patient: _____ Policy Effective Date: _____

ID # _____ Group # _____

Whom should we contact in case of an emergency? _____

His/Her daytime phone number: _____

His/Her relationship to you: _____

Is our clinic your primary care provider? ☐ Yes ☐ No

If not, who is? _____

How did you hear about us? Yellow Pages Insurance Radio Internet Advertisement

Friend/Family (Name) _____ Physician (Name) _____

I VERIFY THE ACCURACY OF THE INFORMATION AND AUTHORIZE THE RELEASE OF ANY MEDICAL INFORMATION NECESSARY TO PROCESS THIS CLAIM AND ASSIGN PAYMENT DIRECTLY TO THE PHYSICIAN FOR THE SERVICES DESCRIBED.

PATIENT'S SIGNATURE: _____ **DATE:** _____