Patient Information

Date_____

DEMOGRAPHICS

Name_____ Birthdate_____ Age_____
First Middle Last

Address_____
City State Zip

Primary Phone #_____ May we leave you a voice mail message at this number? Y / N

Secondary Phone #_____ May we leave you a voice mail message at this number? Y / N

SSN_____ Sex_____ Marital Status (please circle) M / D / S / W

Race_____ Ethnicity_____ Primary Language _____

Email Address _____

Reason For Today's Visit _____

REFERRAL INFORMATION

How Did You Hear About Our Office? (please circle):

Family Doctor / Insurance Co. / Word of Mouth / Friends &/or Family / Other Medical Professional / Other

Referring Physician _____ Specialty_____

Address_____ Phone_____

Primary Care Physician_____ Address_____ Phone_____

EMERGENCY CONTACT (if different from above)

Name_____ Phone_____

Address _____ Relationship To Patient_____

RESPONSIBLE PARTY/GUARANTOR (if different from above)

Name_____ Relationship To Patient_____

Address_____ Phone_____

Employer_____ Phone_____

SSN _____ Birthdate_____

PRIMARY INSURANCE

Insurance Company_____ Name Of Insured (if not patient)_____

ID#/Policy #_____ Group #_____ Policy Effective Date _____

If insured is not patient please answer the following:

Date Of Birth_____ SSN_____ Employer_____

SECONDARY INSURANCE

Insurance Company_____ Name Of Insured (if not patient)_____

ID#/Policy #_____ Group #_____ Policy Effective Date _____

If insured is not patient please answer the following:

Date Of Birth_____ SSN_____ Employer_____

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I AUTHORIZE THE RELEASE OF INFORMATION NECESSARY TO PROCESS INSURANCE CLAIMS FOR MY MEDICAL CARE WITH EASTWIND WOMEN'S HEALTH, INC. I AUTHORIZE PAYMENT OF MEDICAL BENEFITS TO EASTWIND WOMEN'S HEALTH, INC. FOR SERVICES RENDERED. I AM AWARE THAT ALTHOUGH I HAVE INSURANCE, I AM PERSONALLY RESPONSIBLE FOR ALL CHARGES.

Signature of Patient or Responsible Party_____ Date_____