PATIENT INFORMATION **Referred By:**____

Name____

Address____

City__________________________ State_____________ Zip____

CONTACT INFORMATION: Please rank (1, 2, 3) the best way to reach you:

___Home phone number _____________________ □ OK to leave message □ OK to leave message re: appts

___Cell phone number_____________________ □ OK to leave message □ OK to text appt confirmations

___Work phone number_____________________ □ OK to leave message

Social Security Number (**for lab purposes**)_________________ Date of birth________________________________

Employer____ Occupation__________________________________

Marital status:_____________________________ Email____

Primary Care Physician:____

Preferred pharmacy name and phone____

PARTNER INFORMATION

Name____Date of birth____________________________

Employer____Occupation_______________________________

Work phone__________________________

EMERGENCY CONTACT NOT LIVING WITH YOU

Name____Home phone________________________

Relationship to patient____Work phone_________________________

Do you want anyone else to have access to your protected health information? Whom?_____________________

INSURANCE INFORMATION

Insurance carrier:	Insurance carrier:
Primary insured person:	Primary insured person:
Date of birth:	Date of birth:
Employed by:	Employed by:
Relationship to patient:	Relationship to patient:
ID/Policy number:	ID/Policy number:
Group number	Group number
Effective date:	Effective date:

I hereby give consent to the physician and staff of Partners in Women's Health to render such care and treatment as might be required by my condition. Such care can include, but is not limited to diagnostic procedures such as laboratory and imaging examinations, rehabilitation, medical and/or surgical treatment and injections. I also authorize my insurance to pay benefits to my physician.

____

Signature of patient or guardian **Date**

____

Guarantor/Guardian Signature

I, the undersigned have read the Notice of Privacy Practices and fully understand my rights and how my medical information may be used and disclosed and how I can get access to this information.

____

Signature of patient or guardian **Date**