WOMEN'S HEALTH PATIENT UPDATE

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HEALTH DIRECTOR

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MEDICAL DIRECTOR

PLEASE PRINT CLEARLY

PATIENT INFORMATION

NAME: ____________________
LEGAL: FIRST NAME / MIDDLE NAME / LAST NAME / PREFERRED NAME

MAILING ADDRESS: ____________________
ADDRESS / CITY / STATE / ZIP

May we send a statement or receipt to this address? ____ *YES* ____ *NO*

STREET ADDRESS IF DIFFERENT: ____________________

TELEPHONE: (   ) ____________________ (   ) ____________________
CIRCLE ONE: LANDLINE OR CELL PHONE   CIRCLE ONE: LANDLINE OR CELL PHONE

May we contact you by phone? ____ *YES* ____ *NO*

DATE OF BIRTH: ____________ SEX: ____ MALE ____ FEMALE SOCIAL SECURITY# ____________

MARTIAL STATUS: ____ SINGLE ____ MARRIED ____ SEPARATED ____ DIVORCED ____ WIDOWED ____ LIFE PARTNER
____ DOMESTIC PARTNER ____ OTHER ____________

RACE: ____ WHITE ____ ASIAN
____ BLACK OR AFRICAN AMERICAN ____ NATIVE ALASKAN
____ AMERICAN INDIAN ____ NATIVE HAWAIIAN
____ OTHER ____________

ETHNICITY: ____ HISPANIC / LATINO
____ NON HISPANIC / LATINO

PREFERRED LANGUAGE: ____________ COUNTRY OF ORIGIN: ____________

ARE YOU A VETERAN? ____ YES ____ NO IF YES, WAR OR CONFLICT SERVED IN: ____________

EMERGENCY CONTACT: ____________________ (   ) ____________
NAME / RELATIONSHIP / TELEPHONE NUMBER

EMPLOYMENT

NAME OF EMPLOYER: ____________________ TELEPHONE NUMBER (   ) ____________

INSURANCE / PHYSICIAN

DO YOU HAVE INSURANCE : ____ YES ____ NO CHECK ONE: ____ PRIVATE INSURANCE ____ MEDICAID ____ MEDICARE/ ADVANTAGE PLAN

INSURANCE COMPANY: ____________ POLICY #: ____________

NAME OF POLICY HOLDER: ____________ DATE OF BIRTH: ____________

WHAT IS YOUR RELATIONSHIP TO THE INSURED? ____ SELF ____ SPOUSE ____ CHILD ____ OTHER

PRIMARY CARE PHYSICIAN: ____________________

WHAT IS THE REASON FOR YOUR VISIT TODAY? ____________________

____________________ ____________
SIGNATURE OF PATIENT OR PARENT / GUARDIAN   DATE

PLEASE SEE BACK SIDE TO COMPLETE INCOME INFORMATION →

FOR OFFICE USE ONLY:		HIPAA		CONSENTS		BILL RESPONSIBILITY or DECLARATION OF INCOME	UPDATED:		PATAGONIA		FLAGS		NCIR

PLEASE COMPLETE BELOW WITH ALL MEMBERS OF YOUR HOUSEHOLD *INCLUDING YOURSELF*

FIRST NAME/ LAST NAME		RELATIONSHIP		ANNUAL INCOME		EMPLOYER'S NAME
		SELF		$		
				$		
				$		
				$		
				$		
				$		