

**PATIENT INFORMATION SHEET**  
**(Please Print)**

Date \_\_\_\_\_

Primary Care Physician \_\_\_\_\_

Patient Name \_\_\_\_\_

Address \_\_\_\_\_

City, State, Zip \_\_\_\_\_

E-Mail \_\_\_\_\_

SS # \_\_\_\_\_

Date of Birth \_\_\_\_\_

\_\_\_\_\_ Home # \_\_\_\_\_

\_\_\_\_\_ Cell # \_\_\_\_\_

\_\_\_\_\_ Work # \_\_\_\_\_

**(Please check the preferred Phone Number for contact)**

Marital Status    M    S    D    Sep    W

Name of Spouse/Significant Other \_\_\_\_\_

**PHARMACY** \_\_\_\_\_

Phone # \_\_\_\_\_

**PATIENT** Employer \_\_\_\_\_

Address \_\_\_\_\_

Occupation \_\_\_\_\_

Phone # \_\_\_\_\_

Type of Insurance \_\_\_\_\_

Name of Insured Subscriber \_\_\_\_\_

SS # \_\_\_\_\_

Date of Birth \_\_\_\_\_

Relationship to Patient \_\_\_\_\_

Employer \_\_\_\_\_

Address \_\_\_\_\_

Occupation \_\_\_\_\_

Phone # \_\_\_\_\_

Person to Contact in Case of Emergency:  
**(Not In Same Household)**

Relationship to Patient: \_\_\_\_\_

Phone Nos. (Please provide alternate number)

Phone #1 \_\_\_\_\_

Phone #2 \_\_\_\_\_

Referred to our office by \_\_\_\_\_

**I give my permission to Associates in Obstetrics & Gynecology, PC to administer treatment and perform necessary procedures in diagnosing and/or treating my condition. By signing this form I am granting consent to Associates in Obstetrics & Gynecology, PC to use and disclose protected health information for the purposes of treatment, payment and health care operations. You have a legal right to review our Notice of Privacy Practices before you sign this consent and we encourage you read it in full. (You have the right to request how we use and disclose your protected health information. We are not required by law to grant your request, but if we do, we are bound by our agreement. You have the right to revoke this consent in writing, except to the extent we already have used or disclosed your protected health information in reliance of your consent.)**

**I agree to be personally and fully responsible for payment. In case of default I will be responsible for all costs incurred in the collection of this and future outstanding balances.**

**SIGNATURE** \_\_\_\_\_

**DATE** \_\_\_\_\_