

PATIENT INFORMATION

REFERRED BY: \_\_\_\_\_

Patient Name \_\_\_\_\_ Home Phone \_\_\_\_\_  
 Address \_\_\_\_\_ Work Phone \_\_\_\_\_  
 City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Cell Phone \_\_\_\_\_  
 Date of Birth \_\_\_\_\_ SS# \_\_\_\_\_ Marital Status \_\_\_\_\_  
 Employer \_\_\_\_\_ Position \_\_\_\_\_  
 Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
 Primary Care Physician \_\_\_\_\_ Phone \_\_\_\_\_  
 Spouse's Name \_\_\_\_\_ Work Phone \_\_\_\_\_  
 Spouse's Employer \_\_\_\_\_ Cell Phone \_\_\_\_\_

EMERGENCY CONTACT NOT LIVING WITH YOU

Name \_\_\_\_\_ Phone \_\_\_\_\_  
 Address \_\_\_\_\_ Relationship \_\_\_\_\_

PLEASE LIST YOUR INSURANCE INFORMATION BELOW

Guarantor (Policy Holder of Insurance) \_\_\_\_\_  
 Address \_\_\_\_\_ Home Phone \_\_\_\_\_  
 City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
 SS# \_\_\_\_\_ Date of Birth \_\_\_\_\_

Primary Insurance Co. \_\_\_\_\_ Insurance Phone \_\_\_\_\_  
 ID# \_\_\_\_\_ Group# \_\_\_\_\_  Self  Spouse  Parent  Other

Secondary Insurance Co. \_\_\_\_\_ Insurance Phone \_\_\_\_\_  
 ID# \_\_\_\_\_ Group# \_\_\_\_\_  Self  Spouse  Parent  Other

May we contact you at the above phone numbers with results?  YES  NO  
 Appointment Confirmations?  YES  NO  
 May we leave messages at any of the above phone numbers?  YES  NO  
 Do you want anyone else to have access to your protected  
 Information? Whom? \_\_\_\_\_  YES  NO

I hereby give consent to the physician and staff of Partner's 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.

\_\_\_\_\_  
 Patient Signature Date

\_\_\_\_\_  
 Guarantor/Guardian Signature Date

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 Date