Eastside Gynecology – Obstetrics, P.C.

586-415-6200

PLEASE PRINT **TODAY'S DATE**_____

☐ **Patient Centered Medical Home Information Given**

NAME_____SSN_____BIRTHDATE_____

ADDRESS_____CITY_____ZIP_____

(Please Circle Preferred Telephone Number)

PH# (Home)_____(Work)_____(CELL)_____

PHARMACY NAME & PHONE NUMBER: _____

MARITAL STATUS (CIRCLE ONE) Married/Single/Widow/Divorced **E-MAIL** _____

EMPLOYER_____OCCUPATION_____

PRIMARY CARE PHYSICIAN _____PHONE_____

REFERRED BY _____ PREVENTATIVE COVERAGE: **YES** **NO**

INSURANCE POLICY HOLDER NAME & RELATIONSHIP_____

Insurance Policy Holder SSN_____Birthdate_____

EMERGENCY CONTACT_____ PHONE_____

RELATIONSHIP_____

EMERGENCY CONTACT_____PHONE_____

RELATIONSHIP_____

TEST INFORMATION

I **do/do not** *(please circle)* give my permission for the doctor/staff to give any normal test (blood, biopsy, culture, etc) results to a **family member** if I cannot be readily reached.	I **do/do not** *(please circle)* give my permission to leave basic normal test results on my **personal answering machine** if I cannot be readily reached.

I understand and agree that (regardless of my insurance) I am ultimately responsible for the balance for all professional services rendered. I authorize my insurance benefits to be paid to Eastside Gynecology-Obstetrics, P.C. I authorize the release of necessary medical information to my insurance carrier.

_____ _____

Patient's Signature **Date**

_____ _____

Parent/Guardian Signature, if patient is a Minor **Date**

REV 7/2013