EASTSIDE GYNECOLOGY – OBSTETRICS, P.C.

PLEASE PRINT

☐ **Patient Centered Medical Home Information Given**

Name: _____ SSN:_____ Birthdate: _____

Maiden Name:_____

Address: _____ City: _____ Zip: _____

(Please circle preferred telephone number)
Phone #: (Home) _____ (Work) _____ (Cell) _____

Pharmacy Name: _____ Phone: _____

Marital Status: ☐ Married ☐ Single ☐ Widow ☐ Divorced
E-mail: _____

Employer: _____ Occupation: _____
Primary Care Physician: _____ Phone: _____

Referred by: _____ Preventative Coverage: ☐ Yes ☐ No

Insurance Policy Holder & Relationship: _____

Insurance Policy Holder SSN:_____ Birthdate: _____

Emergency Contact: _____ Phone: _____
Relationship: _____

Emergency Contact: _____ Phone: _____
Relationship: _____

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