Southeastern women's health center

Today's Date:_____ Doctor: _____

Patient's LEGAL Name: _____ Gender: **Male** or **Female**

Date of Birth: _____ SSN: _____

Mailing Address: _____

City: _____ State: _____ Zip Code: _____

Home: _____ Work: _____ Cell: _____

Please CIRCLE which form you would like to be contacted for appointment reminders

Phone: _____ Text: _____ Email: _____

Emergency Contact: _____ Phone Number: _____

Relationship: _____

Employment State (Please circle one): **Employed Unemployed Student Retired Disabled**

Employer Name: _____

Marital Status (please circle one): **Single Married Divorced Separated Widowed**

Race: Asian: ___ Black or African America: ___ Native Hawaiian or Pacific Islander: ___ White: ___

American Indian or Alaska Native: ___ Other: ___ Patient Decline: ___

Ethnicity: Hispanic or Latino: ___ Non-Hispanic or Latino: ___ Patient Declines: ___

CURRENT INSURANCE COVERAGE

Please furnish the front desk with CURRENT insurance, Medicare, and/or Medicaid Card for photocopying

Primary Insurance: _____ ID #: _____

Group Number: _____ Policy Holder/Resp for payment: _____

DOB: _____ SSN: _____ Relationship: _____

Secondary Insurance: _____ ID #: _____

Group Number: _____ Policy Holder/Resp for payment: _____

DOB: _____ SSN: _____ Relationship: _____

Authorized persons to receive information regarding my care are listed below:

Name Relationship Phone

_____

_____