# ADVANCED WOMEN'S HEALTH SPECIALISTS

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**PATIENT INFORMATION:**

| LAST NAME: | FIRST NAME: | MIDDLE NAME: | GENDER: ☐ F ☐ M |
|---|---|---|---|
| | | | |

| STREET ADDRESS: | CITY: | STATE: | ZIP CODE: |
|---|---|---|---|
| | | | |

| HOME PHONE #: | WORK PHONE #: | CELL PHONE #: | EMAIL ADDRESS: |
|---|---|---|---|
| (____) _____ LEAVE MESSAGE? ☐ Y ☐ N | (____) _____ LEAVE MESSAGE? ☐ Y ☐ N | (____) _____ LEAVE MESSAGE? ☐ Y ☐ N | |

| DATE OF BIRTH: | AGE: | SOCIAL SECURITY #: | MARITAL STATUS: |
|---|---|---|---|
| _____/_____/_____ | | _____/_____/_____ | ☐ SINGLE ☐ MARRIED ☐ WIDOW ☐ DIVORCED |

ETHNICITY: ☐ HISPANIC ☐ NON-HISPANIC ☐ OTHER ☐ DECLINE

RACE: ☐ ASIAN ☐ BLACK/AFRICAN-AMERICAN ☐ NATIVE HAWAIIAN/PACIFIC ISLANDER ☐ WHITE ☐ DECLINE

**EMERGENCY CONTACT:**

| LAST NAME: | FIRST NAME: | RELATIONSHIP: | PHONE #: |
|---|---|---|---|
| | | | |

**PREFERRED PHARMACY:**

| NAME: | PHONE: |
|---|---|
| | |

**PRIMARY CARE PROVIDER:**

| DOCTOR'S NAME: | DOCTOR'S PHONE: |
|---|---|
| | |

**INSURANCE INFORMATION:**

| PRIMARY INSURANCE: | NAME: | POLICY NUMBER: |
|---|---|---|
| | | |
| **SECONDARY INSURANCE:** | **NAME:** | **POLICY NUMBER:** |
| | | |

**WHO REFERRED YOU TO OUR PRACTICE:**

☐ DOCTOR: _____ ☐ FRIEND: _____

☐ HOSPITAL: _____ ☐ WEBSITE: _____

☐ INSURANCE PLAN: _____ ☐ OTHER: _____

☐ FAMILY: _____

I UNDERSTAND AND AGREE THAT REGARDLESS OF MY INSURANCE I AM ULTIMATELY RESPONSIBLE FOR THE BALANCE OF MY ACCOUNT FOR ANY PROFESSIONAL SERVICES RENDERED. I HAVE READ ALL OF THE INFORMATION AND COMPLETED THE ABOVE ANSWERS. I CERTIFY THAT THIS INFORMATION IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE. I WILL NOTIFY THIS OFFICE OF ANY CHANGES IN MY HEALTH OR IN THE INFORMATION.

SIGNATURE: _____ DATE: _____