



ADVANCED WOMEN'S HEALTH SPECIALISTS

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PATIENT INFORMATION:			
LAST NAME:	FIRST NAME:	MIDDLE NAME:	GENDER: <input type="checkbox"/> F <input type="checkbox"/> M
STREET ADDRESS:		CITY:	STATE: ZIP CODE:
HOME PHONE #: () _____ LEAVE MESSAGE? <input type="checkbox"/> Y <input type="checkbox"/> N	WORK PHONE #: () _____ LEAVE MESSAGE? <input type="checkbox"/> Y <input type="checkbox"/> N	CELL PHONE #: () _____ LEAVE MESSAGE? <input type="checkbox"/> Y <input type="checkbox"/> N	EMAIL ADDRESS:
DATE OF BIRTH: ____/____/____	AGE:	SOCIAL SECURITY #: ____/____/____	MARITAL STATUS: <input type="checkbox"/> SINGLE <input type="checkbox"/> MARRIED <input type="checkbox"/> WIDOW <input type="checkbox"/> DIVORCED
ETHNICITY: <input type="checkbox"/> HISPANIC <input type="checkbox"/> NON-HISPANIC <input type="checkbox"/> OTHER <input type="checkbox"/> DECLINE			
RACE: <input type="checkbox"/> ASIAN <input type="checkbox"/> BLACK/AFRICAN-AMERICAN <input type="checkbox"/> NATIVE HAWAIIAN/PACIFIC ISLANDER <input type="checkbox"/> WHITE <input type="checkbox"/> 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:			
<input type="checkbox"/> DOCTOR: _____	<input type="checkbox"/> FRIEND: _____		
<input type="checkbox"/> HOSPITAL: _____	<input type="checkbox"/> WEBSITE: _____		
<input type="checkbox"/> INSURANCE PLAN: _____	<input type="checkbox"/> OTHER: _____		
<input type="checkbox"/> 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: _____