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PATIENT INFORMATION

FIRST NAME: *Please print* M. *Middle Initial* LAST NAME: *Please print*

DATE OF BIRTH: *MM/DD/YYYY* AGE:

EMAIL:

ADDRESS:

CITY: STATE: ZIP:

SOCIAL SECURITY NUMBER:

SPOUSE/PARTNER NAME:

SPOUSE/PARTNER PHONE: ( )

EMPLOYER:

EMPLOYER'S ADDRESS:

CITY: STATE: ZIP:

EMERGENCY CONTACT NAME:

DAY PHONE: ( ) CELL PHONE: ( )

ADDRESS:

CITY: STATE: ZIP:

WHAT IS THE REASON FOR YOUR APPOINTMENT TODAY?

HOME PHONE: ( )

CELL PHONE: ( )

WORK PHONE: ( )

PHARMACY NAME:

ADDRESS:

CITY:

STATE: ZIP:

PLEASE LET US KNOW WHO REFERRED YOU TO OUR PRACTICE:

PREFERRED LANGUAGE:

PREFERRED METHOD OF CONTACT FOR REMINDER CALLS AND OTHER ELECTRONICALLY GENERATED MESSAGE:

☐ VOICE ☐ TEXT

IF VOICE, PLEASE SELECT PREFERRED NUMBER:

☐ HOME ☐ CELL ☐ WORK

ASSIGNMENT OF BENEFITS RELEASE OF INFORMATION

I hereby authorize my insurance benefits to be paid directly to Capital OB/GYN, Inc. and I understand that I am financially responsible for charges not covered by my insurance company.

I also authorize Capital OB/GYN, Inc. to release any information required to process my claim.

Ô **SIGNATURE** **DATE** *MM/DD/YYYY*