Premier OB-GYN

New Patient Demographics

All information provided is strictly confidential to the full extent permitted by law. No identifying information will be released without your consent.

Name (Last name, First name)	Preferred Name (if applicable)		
Address	**City/ State**	**Zip Code**	**County**
Main Phone Number	**Email Address**		**Date Of Birth**

Social Security #:	Place of Birth	Driver's License #:

Preferred Method(s) of Contact		
Telephone: ____YES ____NO (Okay to leave message: ___YES ___NO)	Mail: ___YES ___NO	No Contact: ___

Marital Status	Sexual Orientation
___Single ___Married ___Divorced ___Widowed ___Living with Domestic Partner	___Heterosexual ___Homosexual ___Bisexual ___ Choose Not to Answer
Gender	**Transgender**
___Male ___Female	___Yes ___No
Preferred Language	**Race (Choose ALL That Apply)**
___English ___Spanish ___Other (specify): __________________	___White ___Black/African American ___American Indian/ Alaska Native ___Asian ___Pacific Islander/ Hawaiian ___Other:

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Ethnicity (Choose One)	Homeless	Agriculture Worker	US Veteran
___Hispanic ___Non- Hispanic	___ Yes ___No	___Yes ___No	___Yes ___No

Highest Level of Education
___High School ___GED ___Associate Degree ___College ___Other:

Emergency Contact			
Name	Date of Birth	Relationship	Phone Number
Does this person know that you are a patient of Zeid Medical Group? ___Yes ___No			
Primary Care Giver			
___ N/A ___ Same As Emergency Contact	Name	Relationship	Phone Number
Legal Guardian			
___ N/A ___ Same as Emergency Contact	Name	Relationship	Phone Number
Health Care Proxy			
___ N/A ___ Same as Emergency Contact	Name	Relationship	Phone Number

Medical Information		
Name of Primary Care Provider	Address	Phone Number
Name of Preferred Pharmacy	Address	Phone Number
Do you have Advanced Directives?		
___ Yes, DO NOT Resuscitate, Medical Power of Attorney, Living Will		___No
Maternity Patients ONLY:		
For your current pregnancy, in what month of your pregnancy did you receive previous care, if applicable? _________________		___ N/A

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Ever receive Care from **ZMG** in the past? If so, when? ___________________	

Insurance Information	
Do you or anyone in your household have Medicaid, Chip, V.A., or other insurance coverage?	
___ Yes ___ No	
What type of Health insurance do you have?	
____ None/ Self Pay ____ Military ____ Medicare Plan ____ Medicaid Plan ____ Private Insurance Plan/ ID#: _____________________ Group#: _____________________ Insurance Company: _____________________ Primary Care Provider (PCP) if HMO Policy: _____________________	
Insured/ Policy Holder's Information	**Insured Employer's Information**
Name: ______________________________ Date of Birth (mm/dd/yyyy): _____________________ Social Security #: _____________________	Name: ____ Address: _______________________________________ Phone Number: (____) _________________
Marketing	
How did you learn about our services? ____ Friend/ Relative ____ In print ____ On Radio/TV ____ Internet ____Referral ____ Community Event ____ Other	

By signing this form, I attest that all the statements I have made, including my answers to all questions are true and correct to the best of my knowledge and belief.

____ ____________________________

Signature of Patient/ Guardian or Power of Attorney Date

____ ____________________________

Signature of Person Who Helped Complete This Form Date