Cedar City Institute of Women's Health

Patient Information

Full **Legal** Name:_____
First Middle Last

Preferred Name:_____ Maiden Name: _____ Social Sec #_____

Date of Birth:_____ Marital Status: ☐Single ☐Married ☐Divorced ☐Widowed

Race:_____ Ethnicity:_____ Language Preference: _____

Mailing Address: _____
Street/PO BOX City/State Zip code County

Primary Phone: _____ Cell Phone: _____ Cell Phone Service Provider: _____

Personal E-mail:_____

Insurance: _____ Secondary Insurance: _____

Policy Holder Name:_____ Date of Birth: _____ Relation:_____

Emergency Contact Name: _____Relationship:_____

Address:_____

Telephone: _____ Cell Phone:_____

Were you referred to our clinic by another doctor? ☐ Yes ☐ No

If yes, doctor's name: _____

If no, how did you hear about our clinic? _____

Preferred pharmacy: _____

I give permission for The Cedar City Institute of Women's Health to *disclose my personal medical information to the following:*

_____ _____ _____
Spouse Parent Other

I give permission for medical information or test results to be left as a voice message or with an answering party (please initial) _____ YES _____ NO

I give permission for CCIOWH to send me text messages regarding clinic reminders (no confidential information will be sent in text messages) (please initial) _____ YES _____ NO

My signature serves as confirmation of accuracy of the above information:

_____
Signature of Patient Printed Name Date

ATTENTION: Due to the new government regulation with health care reform additional personal information is required. Please make sure ALL fields on this form are complete. If you have any questions please talk to our front office representative.