**Women and Adolescents Gynecology Center, LLC**

**Demographics:**

**Patient Last Name**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Patient First Name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Patient Middle Name:** \_\_\_\_\_\_\_\_\_\_\_

**Date of Birth:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Social Security #** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Gender:** □ Female □ Male

**Marital Status:** □ Single □ Married □ Divorced □ Widowed □ Separated

**Nationality** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **Race**: \_\_\_\_\_\_\_\_\_\_\_\_\_ **Ethnicity:** \_\_\_\_\_\_\_\_\_\_\_\_

□ American Indian or Alaska Native □ Not Hispanic or Latino

**Country of Origin** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ □ Asian □ White □ Hispanic or Latino

□ Black or African American □ Not known

**Primary Language:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ □ Native Hawaiian or Other Pacific Islander

**Religion: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Home Address**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **City**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **State and Zip code** \_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Home Phone** ( )\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Cell Phone** ( )\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Work Phone** ( )\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Employer Name**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Employer Address:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Occupation:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Pharmacy Name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **City:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Phone Number** ( )\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Are you a Student?** □ Full Time □ Part Time □ N/A

**Guarantor/Person to receive bills:**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Name** | **Address** | **Home phone** | **SSN#** | **Date of Birth** | **Relationship** |
|  |  |  |  |  |  |

**INSURANCE – COPY FRONT/BACK OF INSURANCE CARD. This section must be completed or all claims will be sent to you for payment. Insurance is filled as a courtesy to you.**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Insurance Name** | **Policy Number** | **Group Number** | **Insured’s Name** | **Insured’s SSN** | **Insured’s DOB** | **Relationship** |
| 1. |  |  |  |  |  |  |
| 2. |  |  |  |  |  |  |

**I hereby authorize the release of information which said insurance company may request concerning treatment for myself of my dependents. It is understood this authorization does not relieve me from responsibility for charges incurred, and any balance not paid by my insurance company, for whichever reason, shall be paid by me upon receipt of billing accordingly.**

**Patient Signature**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Emergency Contact Name**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Phone Number:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Relationship to Patient:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_