All Women OB/GYN, P.S.C.

Patient Demographics Form

Please complete all information and sign below

Date:_____

PATIENT INFORMATION:

Last Name:_____ First Name:_____ Middle Initial:_____

Age:_____ Date of Birth:_____ Social Security#:_____

Preferred Pharmacy: _____ Zip:_____ Do you authorize us to submit prescriptions electronically? Y N

Race: ☐Caucasion ☐African American ☐Native American ☐Asian ☐Other ☐ Decline

Ethnicity: ☐ Hispanic/Latino ☐Not Hispanic/Latino ☐ Decline

Marital Status: ☐Single ☐ Married ☐Divorced ☐Widowed ☐ Other _____

Street Address:_____

City:_____ State: _____ Zip: _____

Home Phone #: _____ Work Ph#: _____ Cell Ph#:_____

Email: _____ Employer:_____

INSURANCE POLICY HOLDER INFORMATION (If other than Self)

First Name: _____ Middle Initial:_____ Last Name:_____

Date of Birth:_____ Social Security #: _____

Employer: _____ Work Ph#: ( ) _____

INSURANCE INFORMATION:

Name of PRIMARY Insurance Plan: _____

Policyholder: _____ Subscriber ID#: _____ Group#:_____

Claims Address:_____

Patient Relationship to Subscriber: SELF SPOUSE CHILD OTHER_____

Name of *SECONDARY* Insurance Plan: _____

Policyholder: _____ Subscriber ID#: _____ Group#:_____

Claims Address:_____

Patient Relationship to Subscriber: SELF SPOUSE CHILD OTHER_____

PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE

I hereby assign all medical and/or surgical benefits to include major medical benefits to which I am entitled, including Medicare, Private Insurance, and any other Health Plan to: **All Women OB/GYN, PSC**

This assignment will remain in effect until revoked by me in writing. A photocopy of this agreement is to be considered as valid as an original. I understand that I am financially responsible for all charges whether or not paid by said insurance. I hereby authorize said assignee to release all information necessary to secure payment.

SIGNED:_____DATE:_____