PAINT CREEK
O · B · G · Y · N

Section I **Patient Information** *Date:*_____

Name (First, Middle, Last):_____ Maiden Name:_____
Address:_____
City:_____ State:_____ Zip:_____
Home Phone: (_____)_____ Work Phone: (_____) _____ Cell Phone: (_____)_____
The best time to contact me is:_____ ☐AM ☐PM on my ☐Home Phone ☐Work Phone ☐Cell Phone
Date of Birth: _____ Social Security Number: _____
Email Address: _____
May we communicate with you by email (including test results)?: ☐Yes ☐No
Check Appropriate Box: ☐Single ☐Married ☐Widowed ☐Separated ☐Divorced
If Married, Name of Spouse: _____
If Employed, Name of Employer:_____
Work Address:_____
City:_____ State:_____ Zip:_____
Whom may we thank for referring you?:_____
Person to contact in case of emergency: _____
Emergency Contact Phone: _____
Pharmacy: _____ Pharmacy Phone: (_____) _____
Pharmacy Address:_____
City: _____ State: _____ Zip: _____

Section II **Primary Insurance Information**

We will make a copy of your insurance card
Subscriber Name (First, Middle, Last):_____ Date of Birth: _____
Relationship to Patient: ☐Self ☐Spouse ☐Parent ☐Other
Subscriber Employed by: _____
Employer Address:_____
City:_____ State:_____ Zip:_____

Section III **Additional Insurance Information**

We will make a copy of your insurance card
Subscriber Name (First, Middle, Last):_____ Date of Birth: _____
Relationship to Patient: ☐Self ☐Spouse ☐Parent ☐Other
Subscriber Employed by: _____
Employer Address:_____
City:_____ State:_____ Zip:_____

The above information is true to the best of my knowledge. I authorize that my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Paint Creek Ob/Gyn to release any information required to process my claims.

Patient/Guardian Signature: _____