PATIENCE MILLER OB-GYN, PLLC

PATIENT INFORMATION SHEET

REVISED 01/2013 (PLEASE PRINT)

PLEASE ANSWER **ALL** QUESTIONS. DO NOT LEAVE ANYTHING BLANK. IF NONAPPLICABLE, PLEASE WRITE N/A. IF ANY INFORMATION IS MISSING, WE WILL NOT BE ABLE TO BILL YOUR INSURANCE COMPANY AND THEREFORE WE WILL BILL YOU.

PATIENT NAME _____
LAST FIRST MI

DATE OF BIRTH _____ AGE _____SSN# _____-____-_____ PHARMACY# _____

ADDRESS _____ CITY _____ STATE _____ ZIP _____

HOME PHONE _____ WORK PHONE _____ CELL PHONE _____

EMPLOYER NAME AND ADDRESS _____

OCCUPATION _____ HIGHEST LEVEL OF EDUCATION _____

EMERGENCY CONTACT _____ RELATIONSHIP _____ PHONE _____

WHO REFERRED YOU TO US? _____

MARITAL STATUS (CIRCLE ONE): SINGLE MARRIED DIVORCED SEPARATED WIDOW

ETHNICITY (CIRCLE **ALL** THAT APPLY): HISPANIC SCANDINAVIAN GERMAN SLOVAK SLAVIC AFRICAN ARAB

MEDITERRANEAN SHEPHARDIC JEW INDIAN IRANIAN CHINESE JAPANESE AUS/ABORIGINE ASHKENAZIJEW OTHER

RACE (CIRCLE ONE): BLACK/AFRICAN AMERICAN WHITE ASIAN AMERICA INDIAN ALASKA NATIVE UNKNOWN

LANGUAGE (CIRCLE ALL THAT APPLY): ENGLISH SPANISH OTHER _____

INSURANCE INFORMATION

PRIMARY INSURANCE _____ OFFICE CO-PAY _____

POLICY HOLDER NAME _____ RELATIONSHIP _____ DOB _____

POLICY HOLDER ID# _____ GROUP# _____

POLICY HOLDER SS# _____

PRIMARY CARE PHYSICAN: _____

SECONDARY/ OTHER INSURANCE _____ OFFICE VISIT COPAY _____

POLICY HOLDER NAME _____ RELATIONSHIP _____ DOB _____

POLICY HOLDER ID# _____ GROUP# _____

POLICY HOLDER SS# _____

I HEARBY AUTHORIZE MY INSURANCE CARRIER TO FURNISH OR RELEASE INFORMATION TO MY PHYSICIAN'S OFFICE CONCERNING MY ILLNESS, TREATMENT, ELIGILBILITY AND BENEFITS. I UNDERSTAND THAT I AM RESPONSIBLE FOR PAYMENT OF SERVICES RENDERED WHICH ARE NOT MEDICALLY NESCESSARY FOR MY CARE.

SIGNATURE OF REPONSIBLE PARTY _____ **DATE** _____