Women's Health of Chicago

PATIENT INFORMATION

DATE _____/_____/_____

PATIENT NAME: LAST _____ FIRST _____ MIDDLE _____

DATE OF BIRTH _____/_____/_____ SOCIAL SECURITY NUMBER _____

RACE (*required information for Patient Protection and Affordable Care Act*):

AFRICAN AMERICAN ☐ AMERICAN INDIAN ☐ ASIAN ☐ CAUCASIAN (WHITE) ☐ HISPANIC ☐ OTHER ☐

PRIMARY CARE PHYSICIAN _____

REFERRING PHYSICIAN (IF DIFFERENT FROM PRIMARY CARE PHYSICIAN) _____

HOW DID YOU HEAR ABOUT US _____

RELATIONSHIP STATUS: SINGLE ☐ MARRIED ☐ DIVORCED ☐ SEPARATED ☐ WIDOWED ☐ DOMESTIC PARTNER ☐

HOME ADDRESS: _____

CITY _____ STATE _____ ZIP CODE _____

HOME PH. (_____) _____-_____ WORK PH. (_____) _____-_____ EXT. _____

CELL PH. (_____) _____-_____ BEST NUMBER TO REACH YOU: _____

EMAIL ADDRESS: (All email addresses will remain confidential): _____

PATIENT'S EMPLOYER _____ OCCUPATION _____

EMPLOYER ADDRESS _____

EMERGENCY CONTACT NAME _____ PHONE (_____) _____-_____

PREFERRED PHARMACY NAME _____

PREFERRED PHARMACY ADDRESS_____

PREFERRED PHARMACY PHONE NUMBER (_____) _____-_____

BILLING INFORMATION

RESPONSIBLE PARTY NAME _____ PHONE (_____) _____ - _____

ADDRESS _____

DATE OF BIRTH ____/____/_____ RELATIONSHIP TO PATIENT _____

INSURANCE COMPANY _____ ID / POLICY NUMBER _____

GROUP NUMBER _____ PAYER ID NUMBER _____

DO WE HAVE PERMISSION TO LEAVE DETAILED MESSAGES ON YOUR VOICEMAIL? ☐ YES ☐ NO

SIGNATURE: _____ BEST NUMBER TO LEAVE MESSAGES: (_____) _____-_____

PATIENT/GUARDIAN SIGNATURE _____ **DATE** ____/_____/_____