Date________________ **PLEASE FILL OUT COMPLETELY**

Panhandle Obstetrics & Gynecology
Patient Information Sheet

_________________________________ _________________________ ___________ __________________________

Last Name **First Name** **MI** **Preferred Name**

____________________________________ _____________________________ ________ ___________

Mailing Address **City** **State** **Zip Code**

_________________________ ______________________________ __________________________

Primary Phone (home or cell?) **Alternate Phone (home or cell?)** **Date of Birth**

Gender: **M/F** **Marital Status**: **single/married/divorced/widowed** ____________________ ____________________

Social Security No. **Driver's License No.**

____________________________________ ____________________________________ _________________________

Patient's Employer **Employment Address** **Work Phone**

____________________________________ _____________________________ __________________________________

Emergency Contact Last Name **First Name** **Relationship to Patient**

____________________________________ ____________________________

Primary Phone **Alternate Phone**

How did you hear about us? Friend_____ Phone Book_____ Dr. Referral_____ Other______________________________

PRIMARY INSURANCE

_______________________________ ____________________________________ __________________________

Company **ID/Member Number** **Group Number**

_______________________________ _________________ _________________ _________________________________

Name of Policy Holder **Policy Holder's SSN** **Policy Holder's DOB** **Address of Policy Holder**

__________________________ ___________________________ ____

Relationship to Patient **Employer of Policy Holder** **Employer's Address/Phone Number**

SECONDARY INSURANCE

_______________________________ ____________________________________ __________________________

Company **ID/Member Number** **Group Number**

_______________________________ _________________ _________________ _________________________________

Name of Policy Holder **Policy Holder's SSN** **Policy Holder's DOB** **Address of Policy Holder**

__________________________ ___________________________ ____

Relationship to Patient **Employer of Policy Holder** **Employer's Address/Phone Number**

____

Primary Care/Referring Physician

Appointment with: Barnett Freeman Hopkins May Bergeron

____

Patient's E-mail Address

____

Name and Address of Pharmacy

My medical information may also be released to:

______________________________ ______________________________

Name **Relationship**

______________________________ ______________________________

Name **Relationship**

ACKNOWLEDGEMENT OF REVIEW OF NOTICE OF PRIVACY PRACTICES

You May Refuse to Sign This Acknowledgement

I, ______________________________________, have reviewed a copy of this office's Notice of Privacy Practices.

Please Print Name ____

Signature ____

Date ____

FOR OFFICE USE ONLY

We attempted to obtain written acknowledgement of review of Notice of Privacy Practices, but acknowledgement could not be obtained because:

________ Individual refused to sign

________ Communication barriers prohibited obtaining the acknowledgement

________ An emergency situation prevented us from obtaining acknowledgement

________ Other (Please specify)