BAYSHORE WOMENS HEALTHCARE

BOARD CERTIFIED IN OBSTETRICS & GYNECOLOGY

Please Note: So that we may maintain the most up to date and accurate information on our patients, we will request that you review and update this form at least once a year.

DATE: _____

PATIENT INFORMATION

Patient Name *(Nombre y Apellido)*: _____ **DOB** *(Fecha de nacimiento)*: _____ **Age** *(Edad)*: _____

Social Security #: _____-_____-_____ **Marital Status**: Single ☐ Married ☐ Divorce ☐

Cell *(Celular)*: _____-_____-_____ **Home** *(Casa)*: _____-_____-_____ **Work** *(Trabajo)*: _____-_____-____ ext.: _____

Address *(Direccion)*: _____ **Email Address** *(Correo Electronico)*: _____

Patient Occupation *(Ocupacion)*: _____ **Employer** *(Empleador)*: _____

Spouse Name *(Nombre del Esposo)*: _____ **Spouse DOB** *(Fecha de Nacimiento del Esposo)*: _____

Spouse Phone *(Cellular del Esposo)*: _____-_____-_____

PHARMACY INFORMATION (Must be provided)

Pharmacy Name: _____ **Pharmacy Address**: _____

Pharmacy Phone #:_____ **Pharmacy Fax #**: _____

INSURANCE INFORMATION

Primary Insurance *(Seguro Primario)* _____ **ID #** _____ **Group #** _____

Policy Holder Name: _____ **Relationship to subscriber**: Self_____ Spouse_____ Parent_____

Policy Holder's DOB: _____

Secondary Insurance *(Seguro Secundario)* _____ **ID #:** _____ **Group #**_____

Policy Holder Name: _____ **Relationship to subscriber**: Self_____ Spouse_____ Parent_____

Policy Holder's DOB: _____

Please check the box If you have no insurance and will be paying out of pocket: ☐

RELEASE OF INFORMATION AND ASSIGNMENT OF BENEFITS:

I directly assign all medical/surgical benefits to_____ and understand that I am financially responsible for all charges whether or not paid by the insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I further agree that a photocopy of this agreement shall be as valid as the original.

Patient Signature: _____ **Date:** _____

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