Patient Information Form

Welcome To Our Office **Harmony OB/GYN**

Today's Date: ____________________
Age: ____________________
Referred By: ____________________
Driver's License #: ____________________
Email: ____________________

In order to serve you properly, we need the following information.
All information is strictly confidential. Please print clearly.

GENERAL

Patient's Name: ____________________ (Last) ____________________ (First) ____________________ (Middle) Birthdate: ____________________ (Month, Date, Year)
Social Security # ______ - ______ - ______ Marital Status: S M D W
Address: ____________________ (Street) ____________________ (City) ____________________ (State) Zip Code: ____________________
Home Phone ( ) ____________________ Work :( ) ____________________ Cell ( ) ____________________
Employer: ____________________ City: ____________________
Name of Spouse (or Parent): ____________________ Address: ____________________
Social Security # of Spouse (or Parent): ____________________ DOB. ____________________ Phone:( ) ____________________

MEDICAL

Chief Complaint/Reason for Visit: ____________________
Date of Last General Physical Exam: ____________________
List any allergies you have (drugs, food, Hay fever, other): ____________________
List any medications you are taking: ____________________
Do you have High blood pressure? ____________________ Diabetes? ____________________
Describe any other conditions we should know about: ____________________
Are you seeing the doctor because of an accident? ____________________

INSURANCE

Primary Insurance Company: ____________________ Policy # ____________________
Group # ____________________
Insured Name: ____________________ Soc. Sec # ______ - ______ - ______
Secondary Insurance Company: ____________________ Policy # ____________________
Group # ____________________
Insured Name: ____________________ Soc. Sec # ______ - ______ - ______
Relation Ship to Insured: ☐ Spouse ☐ Dependent

FINANCIAL

I understand that I am financially responsible for all services to me, including the balance remaining after payment of insurance benefits.

Signed: ____________________ Date: ____________________
(Patient or Parent of Minor)

Assignment of Benefits

I authorize payment of medical benefits to myself of the names provided for professional services rendered.

Signed: ____________________ Date: ____________________
(Subscriber)

Release of Information

I authorize the release of any medical information necessary to process this claim.

Signed: ____________________ Date: ____________________
(Patient or Parent of Miner)

Thank You For Choosing Our Office