Gynecologic Surgeons & Obstetricians, P.C.

Women’s Health Care Center of Williamsburg

**Patient Information**

Last Name First Name M.I. Date of Birth

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_

Street Address City State Zipcode

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_

SSN Marital Status Phone Numbers (check preferred)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_ H: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ M: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Gender Identity:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Sexual Orientation:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Access to Patient Portal YES NO Email address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Contact Preference Voice Email   Text Do Not Contact

Permission to leave detailed voice mail: Yes No

**Current Employer** /Address Job Title Work Phone

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Referring Physician Primary Care Provider**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Race/ Ethnicity:** \_\_Caucasian \_\_Hispanic/Latino \_\_African American \_\_ Asian \_\_Native American \_\_More than One Race \_\_Unknown \_\_ Not Reported – Refused \_\_ Other Race:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Primary Language**: English Spanish Other (Please Specify):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Spouse / Significant Other / Parent or Legal Guardian Information**

Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ SSN \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Employer \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Emergency Contact**

Name and Relationship Phone

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Insurance Information**

Primary Ins:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Name of Insured: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB: \_\_\_\_\_\_\_\_\_\_

Policy # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Group # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Secondary Ins:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Name of Insured: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB: \_\_\_\_\_\_\_\_\_\_

Policy # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Group # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Consent to access pharmacy history**: \_\_ Yes \_\_ No

Payment for services is due in full on the day of your visit unless insurance coverage is in effect. Financial arrangements should be made with the Billing Department prior to surgical or obstetrical care. I understand that:

* My insurance coverage is a contract between me and my insurance company.
* I am responsible for payment of copays, deductibles, & services or items not considered covered benefits.
* I am responsible for obtaining any referrals or authorizations required by my insurance company.
* I am responsible for unpaid balances.

My signature below authorizes my consent for treatment. I have received a copy of Gynecologic Surgeons & Obstetricians, P.C.’s Notice of Privacy Practices, which describes how my health information may be used or disclosed. I assign benefits and authorize payment directly to Gynecologic Surgeons & Obstetricians, P.C. for any medical or surgical services.

Patient Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*\*\*\*Please have your insurance cards and photo I.D. ready for photocopying\*\*\**