South Shore OBSTETRICS & GYNECOLOGY Women's Health Care

Patient Name:____Date:_____________________________
Address:___________________________City:______________________State:________Zip:________
Employer:________________________ Date of Birth:_____________Race:________________________
Occupation:_____________________________Driver's License #:______________________________
Social Security #:_________________________ Ethnicity:_____________________________________
E-Mail Address____

Spouse Name:____Date of Birth:_____________________
Employer:___________________________Occupation:______________Work phone:_______________
Spouse Social Security #:____

Primary Insurance:______________________________ Effective Date:___________________________
Policy Holder:_________________________________ Relationship to Patient:___________________
Policy Holder Date of Birth:______________________ Policy Holder Social Security #:______________
Secondary Insurance:____________________________ Effective Date:___________________________
Policy Holder:_________________________________ Relationship to Patient:___________________

Primary Care physician:____
Whom may we thank for referring you to our Practice?_______________________________________
Would you prefer to receive your appointment reminders/notifications via:
☐ Text message OR ☐ e-mail:
*****Standard text messaging fees may apply-based on your mobile phone service*****

Due to our concern for your confidentiality, we are asking that you sign a release to advise us how we may contact you. **Please select one or more option:**
I give permission for SSWHC to call and identify them as calling from South Shore Women's Health Care and leave detailed information regarding my appointment schedule, test results, prescriptions, outstanding balance or care on my answering machine, cell phone voice mail or work voice mail, as designated below:

Home phone #________________________________Ok to leave a message y n
Work phone #_________________________________Ok to leave a message y n
Cell phone #__________________________________Ok to leave a message y n

I also give permission for SSWHC to speak with the following person(s):____________________
____

Patient Signature:_________________________Date:____________________________________