

# South Shore Women's Health Care

2690 S. Cleveland Avenue

Saint Joseph, MI 49085

Patient Name \_\_\_\_\_ Date \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Employer \_\_\_\_\_ Occupation \_\_\_\_\_

Driver's License # \_\_\_\_\_ Social Security # \_\_\_\_\_

Date of Birth \_\_\_\_\_ Marital Status M S W Sep D

Spouse Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

Employer \_\_\_\_\_ Occupation \_\_\_\_\_ Work Phone \_\_\_\_\_

Spouse Social Security # \_\_\_\_\_

Primary Insurance \_\_\_\_\_ Effective \_\_\_\_\_

Policy Holder \_\_\_\_\_ Relationship to You \_\_\_\_\_

Policy Holder Date of Birth \_\_\_\_\_ Policy Holder Social Security # \_\_\_\_\_

Secondary Insurance \_\_\_\_\_ Effective \_\_\_\_\_

Policy Holder \_\_\_\_\_ Relationship to You \_\_\_\_\_

Primary Care physician you have listed with your insurance carrier \_\_\_\_\_

Whom may we thank for referring you to our practice? \_\_\_\_\_

## TELEPHONE NOTIFICATION CONSENT

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 options.**

I give permission for office staff to call and identify themselves as calling from South Shore Women's Health Care and leave detailed information regarding my appointment schedule, test results, prescriptions or care on my answering machine:

At Home # \_\_\_\_\_

At Work # \_\_\_\_\_

Cell Phone # \_\_\_\_\_

Do not phone me. I understand I will receive all (urgent and non-urgent) notifications and reminders by mail only.

I also give permission for office staff to speak with the following individual(s):

\_\_\_\_\_

Signed \_\_\_\_\_ Date \_\_\_\_\_