GRACE OBGYN, PA
PATIENT INFORMATION

In order to comply with new national standards, meeting meaningful use,
we must have answers to the following questions.

ACCOUNT # ____________________ DATE____________________

PATIENT'S LEGAL NAME _________________________RACE ___________ETHNICITY__________

SOCIAL SECURITY# ______________________ DATE OF BIRTH _________________ AGE _______

MAILING ADDRESS ____

HOME PHONE _____________________ CELL_____________________ MARITAL STATUS ______

EMPLOYER____ WORK PHONE _______________________

OCCUPATION_____________________________________ EMAIL ________________________________

POLICYHOLDER IF NOT YOU _______________________ DATE OF BIRTH ____________________

SSN# OF POLICYHOLDER _______________EMPLOYER OF POLICYHOLDER ______________________

(We must have this information in order to file your visit today.)

IN CASE OF EMERGENCY, NOTIFY ___________________________________ PHONE_________________

NAME OF PRIMARY CARE PHYSICIAN ____________________________(We must have this information.)

HOW DID YOU HEAR ABOUT OUR PRACTICE?____

Lifetime Insurance Authorization: I hearby authorize the undersigned physician to release any information acquired in the course of my examination or treatment to the social security administration, or its intermediaries, or carriers involved in processing and collection of a claim. I understand that I am financially responsible for the charges not covered by this authorization.

____ _______________

Signature Date

IF PATIENT IS A MINOR, PLEASE COMPLETE:

I, ___________________________________, give permission to _____________________________to examine my daughter ____.

Patient or Guardian: ____ Date: __________________

Witness ____ Date: __________________