Winchester Women's Health Care, P.C.

27 Main Street, UL-1
Andover, MA 01810
Phone: (781) 933-9993
Fax: (781) 933-5711
MaryAnn L. Millar, M.D.

Name: _____ DOB: _____ Age: _____
Address: _____
City: _____State: _____ Zip Code: _____
Home Phone: (____) _____ Work Phone: (____) _____
Cell Phone: (____) _____ **Email:** _____

Social Security #:_____Occupation:_____
Referred By: _____Marital Status: _____
Gender Identity: _____ Sexual Orientation: _____
Race:_____ Ethnicity: _____

Emergency Contact Name: _____Phone: _____Relation: _____
Primary Care Physician: _____ Phone: _____

Pharmacy Name, City/Town and Phone #:_____

Primary Insurance Information

Insurance Company: _____
Subscriber Name: _____ Relation to Patient: _____
Policy #:_____ Group#:_____
Employer of Subscriber: _____
Subscriber's Social Security #:_____ Date of Birth: _____

Secondary Insurance Information

ξ **Check here if you do not have Secondary Insurance**
Insurance Name & Address: _____
Policy #:_____ Subscriber's Name: _____
Employer of Subscriber: _____

Privacy Statement Acknowledgement

I acknowledge that I have been offered the privacy statement of Winchester Women's Healthcare to review.
Initial: _____

Contact Preferences

My **primary** contact phone number is (check one): Home _____ Cell _____ Work _____

It is **OK** to leave a detailed message on my primary contact phone number: Yes_____ No _____

It is **OK** to leave a detailed message with: _____

I agree that it is my responsibility to provide the office with my current insurance information. If payment is denied due to inaccurate insurance information I agree to be responsible for any balance.

❖Signature of Patient/Guardian: _____ Date: _____