Steel City Gynecology

PATIENT NAME _____

PREFERRED NAME_____ PREFERRED PRONOUN: SHE / HE /THEY

ADDRESS _____

CITY/STATE/ZIPCODE _____

HOME PHONE (_____)_____CELL PHONE (_____)_____

E-MAIL ADDRESS _____

SOCIAL SECURITY #_____ BIRTHDATE _____

MARITAL STATUS_____OCCUPATION _____

EMPLOYER_____WORK#(____) _____

SPOUSE'S NAME_____OCCUPATION _____

EMPLOYER_____WORK#(____) _____

NAME OF PARENT (if minor) _____

IF STUDENT, NAME OF SCHOOL _____

EMERGENCY NAME & PHONE NUMBER _____

PRIMARY INSURANCE _____

ID #_____GROUP # _____

NAME INSURANCE IS UNDER_____BIRTHDATE_____SS#_____

SECONDARY INSURANCE _____

ID #_____GROUP # _____

NAME INSURANCE IS UNDER_____BIRTHDATE_____SS#_____

***PRIMARY CARE PHYSICIAN** _____

PHONE (_____)_____ **FAX** (_____) _____

PHARMACY PHONE #: _____

"I REQUEST THAT PAYMENT OF AUTHORIZED MEDICARE/INSURANCE BENEFITS BE MADE TO STEEL CITY GYNECOLOGY FOR ANY SERVICES FURNISHED TO ME BY THE PHYSICIANS OR SUPPLIER. I AUTHORIZE ANY HOLDER OF MEDICAL INFORMATION ABOUT ME TO RELEASE TO THE HEALTHCARE FINANCING ADMINISTRATION AND ITS AGENTS ANY INFORMATION NEEDED TO DETERMINE THESE BENEFITS OR THE BENEFITS PAYABLE FOR RELATED SERVICES."

SIGNATURE_____DATE _____

UPDATED-initial & date

_____ _____ _____ _____ _____

_____ _____ _____ _____ _____