South Shore
OBSTETRICS & GYNECOLOGY
Women's Health Care

PATIENT INFORMATION FORM

ID#_____

Staff Initials _____

Patient Name	Maiden (if married)	Date of Birth	Social Security #

Address	City	State	Zip

Ethnicity □ Hispanic □ Not Hispanic	Race	□ Married □ Divorced □ Widowed □ Single	Primary Language	Religion

Employer	Occupation	Primary Care Physician

Driver's License #	Email Address

Home Phone #	Work Phone #	Cell phone #

I give permission to South Shore Women's Health Care staff to call and leave detailed information regarding my appointment, test results, prescriptions, outstanding balance, or care in a message on the following selected phone(s): ☐ ***Home Phone*** ☐ ***Work Phone*** ☐ ***Cell Phone***

□SPOUSE OR □GUARDIAN INFORMATION (If patient is a minor or under 18)

Name	Date of Birth	Phone

Employer	Occupation	Can we speak with him/her about your health □Yes □No

INSURANCE INFORMATION

Primary Insurance	Policy Holder Name	Date of Birth
Relationship to Patient	**Policy #**	**Group #**
Secondary Insurance	**Policy Holder Name**	**Date of Birth**
Relationship to Patient	**Policy #**	**Group #**

FUTURE APPOINTMENT REMINDERS

I would prefer to receive my appointment reminders by: ☐ **Text message** **or** ☐ **Email**

*Standard text messaging fees may apply depending on your cellular service plan

My signature below signifies that I have read and understand South Shore Women's Health Care's financial and HIPPA (protected health information) policy. Furthermore, it acknowledges my responsibility regarding charges related to my care.

Patient/Guardian Signature:_____ **Date:** _____

*Guardian if patient is a minor or under 18.