ID# _____

Staff Initials _____

South Shore Obstetrics & Gynecology Women's Health Care

PATIENT INFORMATION FORM

First and Last Name	Maiden (if married)	Date of Birth	Social Security Number
Address	City	State	Zip
Cell Phone Number	Home Phone Number	Email Address	

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

Employer	Occupation
Primary Care Physician/Location	Are we authorized to fax any office notes they request to them? ☐Yes ☐No

I give my 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 phone(s):

☐ **Home Phone** ☐ **Cell Phone** ☐ **Patient Portal**

I would prefer to receive my appointment reminders by: ☐ Text Message or ☐ Email or ☐ Patient Portal

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

☐ Spouse or ☐ Guardian Information *(Guardian information required for patients under 18 years old)*

Full Name	Date of Birth	Phone
May we speak with them about your health? ☐Yes ☐No	Do you want them as your emergency contact? ☐Yes ☐No	

INSURANCE

Primary Insurance	Policy Holder *(if different from you)*	Their Date of Birth	Relationship to you
Secondary Insurance	Policy Holder *(if different from you)*	Their Date of Birth	Relationship to you

HIPAA

In accordance with Federal government privacy rules implemented through the Healthcare Portability Act of 1996 (HIPAA), in order for your healthcare provider or staff of *South Shore Women's Health Care* to discuss your condition with members of your family or other individuals that you designate, we must obtain your authorization prior to doing so. In the event of a critical episode or if you are unable to give your authorization due to the severity of your medical condition, the law stipulates that these rules may be waived.

First and Last Name	Relationship	Phone Number	Do you want them as your emergency contact?
			☐Yes ☐No
			☐Yes ☐No

Patient Information: I understand I have the right to revoke this authorization at any time and that I have the right to inspect or copy the protected health information to be disclosed. I understand that the information disclosed to any above recipient is no longer protected by federal or state law and may be subject to disclosure by the above recipient. You have the right to revoke this consent in writing. My signature below signifies that I have read and understand South Shore Women's Health Care's financial and HIPAA (protected health information) policy. Furthermore, it acknowledges my responsibility regarding charges related to my care.

Patient/Guardian Signature _____ Date: _____

Patient/Guardian's Printed Name _____