

**PATIENT INFORMATION**

**DATE**

Patient's Name		Martial Status S M W D SEP	Date of Birth	Age	Social Security No.
Street Address	Apt #	City and State		Zip Code	Home Phone No.
Mailing Address	Apt #	City and State		Zip Code	Cell Phone No.
Patient's Employer		Occupation (indicate if student)	How long employed?		
Employer's Street Address	Apt #	City and State		Zip Code	Business Phone No. ext
Drug Allergies			Driver's Lic. No.		
Spouse's/Partner's Name		Date of Birth	Spouses Social Security No.		
Spouses/Partner Employer		Occupation (indicate if student)	How long employed?		
Spouse/Partner Employer Street Address	Apt #	City and State		Zip Code	Business Phone No. ext
Husband's Street Address, if divorced or separated	Apt #	City and State		Zip Code	Home Phone No.
Emergency Contact w/ Relationship	Street Address		City and State	Zip Code	Home Phone No.
Emergency Contact w/ Relationship	Street Address		City and State	Zip Code	Home Phone No.

**IF PATIENT IS A MINOR OR STUDENT**

Mother's Name	Street Address, City, State, and Zip Code			Home Phone No.
Mother's Employer	Occupation	How long employed?		
Mother's Employer Street Address	City and State		Zip	Business Phone No. ext
Father's Name	Street Address, City, State, and Zip Code			Home Phone No.
Father's Employer	Occupation	How long employed?		
Father's Employer Street Address	City and State		Zip	Business Phone No. ext

**INSURANCE INFORMATION**

1	Name of Insurance Company	Policy No.	Group No.
2	Name of Insurance Company	Policy No.	Group NO.

\_\_\_\_\_  
Email Address

\_\_\_\_\_  
Referring or primary M.D.

With regard to medical care and services provided or to be provided. IT IS AGREED that The ATTENDING PHYSICIAN will provide medical care and services to the patient, to the best of his skills and knowledge, which in light of circumstances is possible and practical. The PATIENT will cooperate fully with the ATTENDING PHYSICIAN by obtaining such medications as are prescribed, by following the instructions of the ATTENDING PHYSICIAN, by adhering to such treatment or regimen or course of action as may be set forth, for obtaining all necessary referrals or authorizations, and by paying all fees and charges in full as billed or as provided by prior special arrangements. IT IS AGREED that: Because of differences in human constiution and response, it is no way possible to warrant the outcome of such medical care and services.

I hereby authorize payment of insurance benefits available for medical/surgical services to: CAMELLIA WOMEN'S HEALTH. I authorize the release of any medical or other information necessary to process insurance claims.

\_\_\_\_\_  
Dated Patient Signature

If the PATIENT is a minor or incompetent, the parent or guardian should sign here, and in addition the minor or incompetent PATIENT should sign above, if possible.

\_\_\_\_\_  
Dated Parent or Guardian

\_\_\_\_\_  
Dated Attending Physician