ALL ABOUT WOMEN OB/GYN

PATIENT DEMOGRAPHICS

NOTE: In compliance with the American Recovery and Reinvestment Act of 2009 (AARA) to demonstrate Meaningful Use, we are **required** to capture demographic data including your preferred language, race and ethnicity.

LAST NAME	**FIRST NAME**	**MIDDLE INITIAL**
SOCIAL SECURITY NUMBER	**PRIMARY CARE PHYSICIAN**	**DATE OF BIRTH**
GENDER [ ] Female [ ] Male	**MARITAL STATUS** [ ] Single [ ] Married [ ] Divorced [ ] Widowed [ ] Partner	
STREET ADDRESS	**CITY/STATE**	**ZIP CODE**
HOME PHONE *(include area code)*	**WORK PHONE** (*include area code*)	**CELL PHONE** (*include area code*)
EMAIL ADDRESS (*Please print clearly*)	**STUDENT** [ ] No [ ] Full Time [ ] Part Time	**EMPLOYER**
RACE OF PATIENT [ ] American Indian/Alaskan Native [ ] Asian [ ] Black/African American [ ] White [ ] Native Hawaiian/Other Pacific Islander [ ] Unknown [ ] Declined to answer	**PREFERRED LANGUAGE** [ ] English [ ] Spanish [ ] Other _____	**ETHNICITY OF PATIENT** [ ] Hispanic Origin [ ] Non Hispanic Origin [ ] Unknown [ ] Declined to answer
PHARMACY NAME	**PHARMACY ADDRESS**	**PHARMACY PHONE NUMBER**
SPOUSE OR PARENT'S NAME	**SPOUSE OR PARENT'S EMPLOYER**	**SPOUSE OR PARENT'S PHONE NO.** *(work and (cell)*

PRIMARY INSURANCE POLICY INFORMATION

NAME OF INSURANCE COMPANY/PLAN	**POLICY NUMBER**		**GROUP NUMBER**
INSURED'S NAME	**INSURED'S RELATIONSHIP TO PATIENT**	**INSURED'S DATE OF BIRTH** *(mm/dd/yy)*	**INSURED'S SS#**

SECONDARY INSURANCE POLICY INFORMATION (IF APPLICABLE)

NAME OF INSURANCE COMPANY/PLAN	**POLICY NUMBER**		**GROUP NUMBER**
INSURED'S NAME	**INSURED'S RELATIONSHIP TO PATIENT**	**INSURED'S DATE OF BIRTH** *(mm/dd/yy)*	**INSURED'S SS#**

EMERGENCY CONTACT INFORMATION

NAME	**RELATIONSHIP**	**PHONE NUMBER**

I authorize my insurance benefits to be paid directly to the physician and I am financially responsible for all charges. I hereby consent to the release and re-disclosure of my medical record to enable or facilitate collection, verification, or settlement of my account for any amounts due from me or my third party payor, health maintenance organization, insurer, or other health benefit plan. This consent applies to All About Women Ob/Gyn, or any of its affiliates or agents, lenders, or any third party servicer acting for All About Women Ob/Gyn or any of its affiliates. I also authorize All About Women Ob/Gyn to test my blood for hepatitis and/or the AIDS virus, if in its opinion an employee has suffered an exposure incident as a result of my treatment, as defined by the Occupational Safety and Health Administration.

_____ _____

Signature **Date**