Patient Information

Patient #: ______ Gender: ______ Date of Birth: ______

Last Name: ______ Age: ______

First Name: ______ Initial: ______ Social Security #: ______

Address: ______ Home Phone: ______

City/State/Zip: ______ Cell/Work Phone: ______

Email Address: ______

RESPONSIBLE PARTY

Account #: ______ Patient Relationship to Guarantor: ______

Last Name: ______ Gender: ______ Marital Status: ______

First Name: ______ Date of Birth: ______ Race: ______

Address: ______ Social Security #: ______

City/State/Zip: ______ Home Phone: ______

Employer: ______ Work Phone: ______

Employer Address: ______ Employer City/State/Zip: ______

INSURANCE INFORMATION

Primary Ins: ______ Policy/Suscriber: ______

Address: ______ Insured Policy ID: ______

City/State/Zip: ______ Group Number: ______

Plan Phone: ______ Date of Birth: ______

Effective Dates: ______ Patient Relationship to Suscriber: ______

Second Ins: ______ Policy/Suscriber: ______

Address: ______ Insured Policy ID: ______

City/State/Zip: ______ Group Number: ______

Plan Phone: ______ Date of Birth: ______

MISCELLANEOUS INFORMATION

First day of your last menstrual period? ______

What is the best telephone number to contact you?

Phone#: ______

I, authorize Miami Center of Excellence for OB/GYN. message containing detailed Medical information to listed above.

SIGNATURE: ______

EMERGENCY CONTACT INFORMATION

Emergency Contact: ______

Patient Relationship to Contact: ______

Contact Home Phone: ______

Contact Work Phone: ______

What is your preferred **Pharmacy's Phone** number:

______

Who referred to us? ◯ Friend ◯ Relative ◯ Physician

Is this visit for a second opinion? ☐ YES ☐ NO

Are you pregnant? ☐ YES ☐ NO Last LMP: ______

MEDICAL AUTHORIZATIONS AND RELEASE OF INFORMATION

INSURANCE AUTHORIZATION AND ASSIGNMENT. I hereby authorize MIAMI CENTER OF EXCELLENCE FOR furnish information to any Insurance Carrier concerning illness and treatments and hereby assign MIAMI CENTER OF EXCELLENCE FOR OB/GYN, medical services rendered to myself or dependents. **I UNDERSTAND THAT I AM RESPONSIBLE FOR ANY AMOUNT NOT COVERED BY**

Signature ______ Date: ______