PATIENT INFORMATION

Date _________ /____________ /___________

Patient's Name ______________________

Social Security Number _________/_________/_________

Sex ◯ Male ◯ Female

Date of Birth _________/_________/_________

Age ________

Street Address ◯ Permanent ◯ Temporary ______________________

Apt/Suite/Unit ______________

City / State _________/_________

Zip Code ______________

Country ______________

Marital Status: ◯ Single ◯ Married ◯ Widowed ◯ Divorced ◯ Separated ◯ Domestic Partner

Race (check all that apply) ◯ American Indian/Alaskan Native ◯ Asian ◯ White ◯ Black/African American ◯ Native Hawaiian/Pacific Islander ◯ Other

Ethnicity (check one) ◯ Hispanic ◯ Non-Hispanic

Primary Language ◯ English ◯ Spanish ◯ Other

Mobile Phone ______________

e-mail ______________

Patient's Occupation ______________

Patient's Employer ______________

How long employed ______________

Preferred method of communication ◯ Call ◯ Text ◯ e-mail

Driver's License Number ______________

Employer's Street Address ______________

City / State _____________/_____________

Zip Code ______________

Primary Care Physician Name ______________

Phone Number ______________

Fax Number ______________

How did you hear about us? ◯ Referring Provider ◯ Friend or Family ◯ Internet ◯ Walk In

Spouse/Domestic Partner Name ______________

Spouse/Partner Employer ______________

How long employed ______________

Spouse/ Partner Occupation ______________

Spouse/Partner's Employer Street Address ______________

City / State ____________/______________

Zip Code ______________

Spouse/Partner Mobile Phone ______________

Emergency Contact Name ______________

Relationship to Patient ______________

Emergency Contact Mobile Phone ______________

Emergency Contact Street Address ______________

Apt/Suite/Unit ______________

City / State ____________/______________

Zip Code ______________

Country ______________

IF THE PATIENT IS A MINOR OR STUDENT

Mother's Name ______________

Street Address ______________

City / State ____________/______________

Zip Code ______________

Mother's Occupation ______________

Mother's Employer ______________

How long employed ______________

Mother's Mobile Phone ______________

Mother's Employer Street Address ______________

City / State ____________/______________

Zip Code ______________

Mother's Alt Phone ______________

Mother's Social Security # / /

Mother's Date of Birth / /

Mother's Drivers License Number ______________

Mother's Business Phone ______________

Father's Name ______________

Street Address ______________

City / State ____________/______________

Zip Code ______________

Father's Occupation ______________

Father's Employer ______________

How long employed ______________

Father's Mobile Phone ______________

Father's Employer Street Address ______________

City / State ____________/______________

Zip Code ______________

Father's Alt Phone ______________

Father's Social Security # _________/_________/_________

Father's Date of Birth _________/_________/_________

Father's Drivers License Number ______________

Father's Business Phone ______________

INSURANCE INFORMATION

Insurance Company ______________

◯ PPO ◯ POS ◯ HMO ◯ EPO ◯ INDEMNITY ◯ MEDICARE/MEDICAID ◯ W/C ◯ SELF PAY

Primary Insurance Holder ______________

Date of Birth _________/_________/_________

Employer's Street Address ______________

Policy Holder Street Address ______________

PHARMACY INFORMATION

Primary Pharmacy Name ______________

Pharmacy Address ______________

Pharmacy Fax ______________

Pharmacy Phone ______________

PHYSICIAN RELEASE AND ASSIGNMENT

I hereby authorize payment directly to Miami Women's Health and Asthma Center of benefits due to me from my insurance company otherwise payable to me. I further authorize the release of any medical information required by my insurance carrier(s). A copy of this authorization may be used in lieu of the original. I authorize any holder of medical or other information about me to release to the Social Security Administration and Health Care Financing Administration or its intermediaries or carriers any information needed for this or a related Medicare claim as required by law. I request payment of medical insurance benefits either to myself or to Miami Women's Health and Asthma Center who accepts assignment. I understand that I am financially responsible for charges regardless of coverage.

Patient's / Guarantor's Signature:______________________________ Date_________/________/_______