Vermont Gynecology

PATIENT INFORMATION FORM

Full legal name: _____ **Date of Birth:** __ __ / __ __ / _____
FIRST MIDDLE LAST

Preferred/Chosen name: _____ **Social Security #:** _____-____-_____

Current mailing address:

_____
STREET ADDRESS TOWN STATE ZIP

Permanent/Alternate mailing address (if different than above):

_____
STREET ADDRESS TOWN STATE ZIP

❑ We have your permission to discuss your care/results with (1) Name/phone _____

(2) Name/phone _____ (3) Name/phone _____

Phone numbers (✓ *best place(s) to reach you)*:

❑ Home: _____ ❑ Cell: _____

❑ Work: _____ ❑ Other: _____

O.K. to leave a detailed message? Y/N If so, where? _____

Email address: _____

Emergency contact (required):

Name: _____

Relationship to you: _____

Phone: (_____)_____

Preferred Pharmacy: _____ Pharmacy Address/Town/City: _____

Demographics (Note: Some medical conditions are more common in certain groups. The following may be helpful in your care.)

Sex assigned at birth: ❑ Male ❑ Female ❑ Decline to answer

Gender: ❑ Male ❑ Female ❑ Transman/FTM ❑ Transwoman/MTF ❑ Other: _____ ❑ Decline to answer

Race (✓ all that apply): ❑ American Indian or Alaskan Native ❑ Asian ❑ Black or African American ❑ Hispanic ❑ Native Hawaiian or other Pacific Islander ❑ White ❑ Other race: _____ ❑ Decline to answer

Ethnicity: ❑ Hispanic/Latino ❑ Not Hispanic/Latino ❑ Decline to answer

Primary language: ❑ English ❑ Spanish ❑ French ❑ Chinese ❑ Japanese ❑ Indian (includes Hindi & Tamil) ❑ Russian ❑ Bosnian ❑ Serbo-Croatian ❑ Vietnamese ❑ Bantu ❑ Other: _____ ❑ Language interpretation services needed?

Relationship status (✓ all that apply): ❑ Single ❑ Married ❑ Civil Union ❑ Partnered ❑ Separated ❑ Divorced ❑ Widowed

If you are using your insurance today:

Please give your insurance card to the person at the front desk. If you choose to bill insurance for which you are not the primary subscriber, the policy holder may receive mail from the insurance company detailing where you received health care and the nature of the care.

Your relationship to the person holding the insurance policy: _____

Insurance Subscriber:_____ **Date of Birth:** __ __ / __ __ / _____

Please read the following and sign below.

VTGyn may release any medical information and/or medical records needed by my health insurance company for determining benefits or paying claims. Payments from my health insurance company will be made directly to VTGyn. I understand that I am responsible to pay any deductibles, co-payments, or co-insurances for services not covered by insurance.

_____ _____
SIGNATURE DATE

FOR OFFICE USE ONLY:

Date _____ **Initials** _____ **Patient #** _____