



PATIENT INFORMATION FORM

Full legal name: \_\_\_\_\_ Date of Birth: \_\_\_/\_\_\_/\_\_\_
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: \_\_\_\_\_
Emergency contact (required):
Name: \_\_\_\_\_
Relationship to you: \_\_\_\_\_
O.K. to leave a detailed message? Y/N If so, where? \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_
Email address: \_\_\_\_\_
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 #