FOXHALL OB/GYN ASSOCIATES

Account No:

PATIENT INFORMATION SHEET

DEMOGRAPHIC INFORMATION

First Name:	Last Name:	MI:
Preferred or Nickname:	Maiden Name:	DOB: mm/dd/yyyy
SSN:	Marital Status (Circle One) Married Single Widow Divorced	
Sex:	Primary Language:	
Address:	Apt/Unit:	City:
State:	ZIP:	County:
Is this your primary address? Y / N (If not please provide further information)		
Employer:	City, State:	
Race:(Circle One) African American/Black American Indian/Alaskan Native Asian Caucasian/White Declined Nat Hawaiian/Pacific Islander Other Race Unknown		
Ethnicity: (Circle One) Declined Hispanic or Latino Not Hispanic or Latino Unknown		

CONTACT INFORMATION

Place a check in the box next to your primary phone number:	Home: ☐	Work: ☐	Cell: ☐
Email Address:			

What is your preferred method of communication for appointment reminders? (Circle One)	Phone	Email	Text	Declined

PHARMACY AND PROVIDER INFORMATION

What is your preferred Pharmacy?	Pharmacy Phone:
Approximate Location: (City, cross street, etc.)	
Referring Doctor:	Primary Care Doctor:

EMERGENCY CONTACT

Name:	Relationship:	DOB: mm/dd/yyyy	Phone:
Do you have a Living Will? Y / N	Do you have Power of Attorney for healthcare? Y / N		

How did you hear about us? Physician ☐ Family/Friend ☐ Health Plan ☐ Website/Internet ☐ Seminar/Lecture ☐ Student Health ☐ ER ☐ Other ☐

INSURANCE/BILLING INFORMATION Please fill out only if you do not have your insurance card with you.

Primary Insurance	
Primary Ins:	Policy ID#:
Policy Holder:	Group#:
Policy Holder Relationship to Patient:	
If patient is not policy holder, what is the holder's DOB? mm/dd/yyyy	Address? (If not the same as patient)

Secondary Insurance	
Secondary Ins:	Policy ID#:
Policy Holder:	Group#:
Policy Holder Relationship to Patient:	
If patient is not policy holder, what is the holder's DOB? mm/dd/yyyy	Address? (If not the same as patient)

Patient Signature: _____ Date: _____