

SCOTTSDALE WOMEN'S CARE
PATIENT DEMOGRAPHIC INFORMATION SHEET
(Please Print)

SS#: _____ - _____ - _____ PATIENT'S NAME: _____
LAST NAME, FIRST NAME MIDDLE INITIAL

PERMANENT ADDRESS: _____ APT #: _____

CITY: _____ STATE: _____ ZIPCODE: _____

LOCAL ADDRESS: _____ APT #: _____

CITY: _____ STATE: _____ ZIPCODE: _____

DATE OF BIRTH: ____/____/____ SEX: (M / F) MARITAL STATUS:(S / M / W / D)
MONTH DAY YEAR

PHONE#:(____)____-____ WORK#: (____)____-____ OTHER#: (____)____-____

PRIMARY CARE PHYSICIAN: _____ PCP PHONE #:(____)____-____
LAST NAME, FIRST NAME

PATIENT EMPLOYER: _____

PRIMARY INSURANCE

INS. CO. NAME: _____

POLICY #: _____ GROUP#: _____

RELATION TO PATIENT: _____

INSURED'S NAME: _____

INSURED'S DOB: _____ M / F

INSURED'S EMPLOYER: _____

INSURED'S SS#: _____

SECONDARY INSURANCE

INS. CO. NAME: _____

POLICY #: _____ GROUP#: _____

RELATION TO PATIENT: _____

INSURED'S NAME: _____

INSURED'S DOB: _____ M / F

INSURED'S EMPLOYER: _____

INSURED'S SS#: _____

WHO MAY RECEIVE INFORMATION REGARDING YOUR PROTECTED HEALTH INFORMATION?
(CHECK ALL THAT APPLY)

SPOUSE: _____ NAME: _____ DOB: ____/____/____

CHILDREN: _____ NAME: _____ DOB: ____/____/____

NAME: _____ DOB: ____/____/____

NAME: _____ DOB: ____/____/____

NAME: _____ DOB: ____/____/____

PARENT/GUARDIAN: _____ NAME: _____ DOB: ____/____/____

SIGNIFICANT OTHER/ FRIEND: _____ NAME: _____ DOB: ____/____/____

MAY WE LEAVE MESSAGES REGARDING TEST RESULTS AND APPOINTMENTS ON YOUR ANSWERING MACHINE?

YES _____ NO _____

I HAVE RECEIVED A COPY OF THE PRIVACY RULES FROM THIS PROVIDER AND AUTHORIZED THE ABOVE LIST OF PERSONS WHO MAY RECEIVE MY PROTECTED HEALTH INFORMATION. I MAY REVOKE THIS AT ANY TIME BY GIVING WRITTEN NOTIFICATION TO THIS PROVIDER.

DATE: _____ SIGNATURE: _____

CIRCLE ONE: (PATIENT / PARENT / GUARDIAN)

IF YOU HAVE TWO INSURANCE COMPANIES, PLEASE PRESENT BOTH CARDS SO THAT WE MAY FILE WITH YOUR SECONDARY CARRIER FOR ANY BENEFITS DUE TO YOU.