ELITE GYNECOLOGY

PATIENT INFORMATION FORM

Last Name:	**First Name**:
Date of Birth: **Age**:	**SSN**:
Address:	**City**: **State**: **Zip**:
Email:	**Cell #:**
Home#:	**Work#**:
Marital Status: [ ] Married [ ] Single [ ] Separated [ ] Divorced [ ] Widowed [ ] Partner	
Ethnicity: [ ] Not Hispanic/Latino [ ] Hispanic/Latino [ ] Declined to Specify	
Race: [ ] White [ ] Black/African American [ ] Asian [ ] Chinese [ ] American Indian/Alaska Native	
Birth Sex: [ ] Female [ ] Male Gender Identity (optional) :_____	
Sexual Orientation: [ ] Straight/Heterosexual [ ] Lesbian [ ] Bi-Sexual [ ] Choose not to disclose	
Primary Language: [ ] English [ ] Spanish [ ] French [ ]Other:_____	
Employment Status: [ ] Full Time [ ] Part Time [ ] Retired **Student Status**: [ ] Full Time [ ] Part Time	
Name of Pharmacy: **Phone #:**	
Emergency Contact Name: **Phone #:**	
Referred By: **Primary Care Physician:**	

Guarantor/Person Financially Responsible for Payment of Healthcare Services if Other Than the Patient

Last Name:_____ [ ] Mr [ ] Mrs Sex: [ ] Male [ ] Female
First Name:_____ Date of Birth:_____Age:_____
Address:_____ SSN:_____
City/State/Zip:_____ Phone #:_____

Primary Insurance	Secondary Insurance
Ins Company:_____	Ins Company:_____
Policyholder Name:_____	Policyholder Name:_____
Policyholder ID:_____	Policyholder ID:_____
Policyholder Date of Birth:_____	Policyholder Date of Birth:_____
Group Number:_____	Group Number:_____
Relationship to Patient:_____	Relationship to Patient:_____

Consent for Treatment: I consent and authorize Elite Gynecology, LLC to provide me medical treatment and to use and release my protected health information for treatment, payment and healthcare operations as allowed by HIPAA and as described in the Notice of Privacy Practices, a copy of which has been made available to me.

Authorization for Release of Medical Information: I understand that my medical information, including complete medical records, test results, and billing information may be released to my insurance company and to other medical professionals and/or medical care institutions for treatment and payment purposes.

Assignment of Insurance Benefits: I hereby assign all my rights and allow payment to be made directly to Elite Gynecology, LLC for all medical/surgical benefits otherwise payable to me under terms of my insurance.

Payment Guarantee: I understand and agree that I am responsible for paying all co-payments, co-insurance, deductibles and non covered services rendered by Elite Gynecology, LLC, including charges for services not covered by insurance. I consent and authorize Elite Gynecology, LLC and its third party agents to contact me for matters related to my account.

To the best of my knowledge the information I have given on this form is accurate and true. I know it is my or my legal guardian's responsibility to keep Elite Gynecology, LLC informed of changes to my contact information a failure to do so may interfere with the ability to contact me concerning my healthcare.

I understand this consent/authorization is valid for one year from date signed.

Patient Signature: _____Date:_____