GynoFit MD

Women's Health & Medical Weight Loss Expert

Patient Demographic Information

PATIENT INFORMATION

*Fields with * are required*

*Last Name: ______________ *First Name: ______________ Middle Initial: ______

If minor, name of responsible parent: ______________

Name you would like to appear on your health records: ______________

*DOB: __________ Social Security #: __________ Driver's License #: __________

*Home Address: ______________ APT/Suite #: __________

*City: __________ *State: __________ *Zip: __________

*Pick one: Home #: ☐ __________ Mobile #: ☐ __________ (Checkmark the best number to use)

*Email Address: ______________

Occupation: ______________

*Pharmacy Name: __________ Phone: __________ Cross Streets: __________

RX BIN #: ______________

EDUCATION, LANGUAGE & DEMOGRAPHICS

Preferred Language: __________ Do you need and interpreter? __________

Ethnicity: __________ Race: __________

IF APPLICABLE, NAME OF SPOUSE / DOMESTIC PARTNER

Last Name: __________ First Name: __________ Middle Initial: ______

CONTACT INFORMATION FOR RESPONSIBLE PARTY / SPOUSE / PARENT

If some info same as above, leave blank

Last Name: __________ First Name: __________ Middle Initial: ______

Social Security #: __________ Relationship to patient: __________

Address: __________ City: __________ State: ______ ZIP: ______

Home #: __________ Cell #: __________ Email Address: __________

*Patient's Primary Care Provider: __________ Phone: __________

Specialist Provider: __________ Phone: __________

How did you hear about our office? ______________

Emergency Contact: __________ Relationship: __________ Phone: __________

Billing Information & Responsible Party/Insurance Information

Last Name: ____________________ First Name: ____________________ Middle Initial: ________

PRIMARY INSURANCE INFORMATION

Primary Insurance Name: ______________________________

Claims Address: ____________ City: ____________ State: ____________ ZIP: ________

Phone: ____________ Effective Date: ____________

ID/Policy #: ____________ Group #: ____________

Policyholder's Name: ____________ Relationship to Patient: ____________

Date of Birth: ____________ Policyholder's SSN#: ____________ Phone: ________

Policyholder's Employer: ______________________________

OTHER INSURANCE INFORMATION

Primary Insurance Name: ______________________________

Claims Address: ____________ City: ____________ State: ____________ ZIP: ________

Phone: ____________ Effective Date: ____________

ID/Policy #: ____________ Group #: ____________

Policyholder's Name: ____________ Relationship to Patient: ____________

Date of Birth: ____________ Policyholder's SSN#: ____________ Phone: ________

Policyholder's Employer: ______________________________

AUTHORIZATION TO RELEASE INFORMATION AND ASSIGNMENT OF BENEFITS

I authorize payments of medical benefits to the provider for the services rendered, or to be rendered in the future, without obtaining my signature on each claim submitted, and understand the signature will bind me as though I personally signed the claim. I also authorize the release of any medical information necessary; I UNDERSTAND I AM RESPONSIBLE FOR ALL CHARGES. If this account should be referred to a collection agency, I will be responsible for any collection and/or legal fees. I have read and understand the office policies and procedures.

☐ *By checking this box, you agree to receive text message from GynoFitMD regarding your healthcare and appointments. Message freq. varies but will not be more than (10) messages per day unless there is a notification event. Msg & Data rates may apply. Reply HELP for help. Reply STOP to opt out.*

SMS SHARING DISCLOSURE: No mobile information will be shared with third parties/affiliates for marketing/promotional purposes at any ttime.

Patient Signature: ______________________________ Date: ____________

Patient Representative/Parent: ______________________________ Date: ____________

For patients requiring translation or verbal reading of the document, the reader of translator may document and sign below.

Reader/Translator: ______________________________