Care New England MEDICAL GROUP | WOMEN & INFANTS

# Division of Urogynecology & Reconstructive Pelvic Surgery

101 Plain Street | 5th Floor | Providence, Rhode Island 02903

## PLEASE PRINT CLEARLY

Name of Patient: _____ Maiden Name: _____

Street: _____ City: _____ State: _____ Zip Code: _____

Primary Phone #: _____ Alternate Phone #: _____

Can we leave a detailed voicemail/message? ☐ Yes ☐ No If Yes, Please specify ☐ Primary Phone# ☐ Alternative Phone#

Age: _____ DOB: _____ Social Security #: _____

Peferred Language: _____ Do you prefer an interpreter for medical information? ☐ Yes ☐ No

Employer: _____ Occupation: _____ Work Phone #: _____

Street: _____ City: _____ State: _____ Zip Code: _____

Email: _____

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**Marital Status:** ☐ Single ☐ Marrried ☐ Widowed ☐ Divorced ☐ Legally Separated ☐ Other ☐ Significant Other ☐ Unknown

Spouse/Partner's Name: _____

SS #: _____ DOB: _____ Employer: _____

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**In Case Of An Emergency**

Name: _____ Relationship: _____ Phone #: _____

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**Insurance #1:** _____ Policy #: _____

Subscriber: _____ DOB: _____ SS#: _____

**Insurance #2:** _____ Policy #: _____

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**Name of Primary Physician:** _____

Street: _____ Phone #: _____

City: _____ State: _____ Zip Code: _____

**Referring Physician Name:** _____ Phone #: _____

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**Pharmacy Name:** _____ Phone #: _____

Pharmacy Address: _____

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Do you give permission to discuss all your protected health information with anyone else? ☐ Yes ☐ No **If yes, please list below**

Name: _____ Relationship: _____ Phone Number: _____

Name: _____ Relationship: _____ Phone Number: _____

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**THE POLICY OF THIS OFFICE IS NOT TO MAIL STATEMENTS TO DEFRAY COSTS TO YOU.**
**ALL PAYMENTS ARE EXPECTED ON THE DAY OF TREATMENT. THANK YOU.**

_____ _____

Patient's Signature or Responsible Party Date

Patients who carry Health Care Insurance should remember that professional services are rendered and charged to the Patient and not to the Insurance Company. If the insurance company does not reimburse this office, it is the responsibility of the patient to take care of any unpaid claim. This office cannot accept responsibility for the negotiating of a settlement on disputed claim. If you have any questions, please let us know. Thank you.

**OFFICE USE ONLY**
REVIEWED BY:

INITIALS: _____

DATE: _____