Obstetrician/Gynecologist Name: _____

(*Dr. Jennifer Borson, Dr. Jeanne Debono, Dr. Michelle Herman, Dr. Jennifer Kaplan, Dr. David Lipschutz, Dr. Alvin Schoenberger, Dr. Keri Thompson, Dr. Lester Voutsos)*

Patient Name: _____

Address: _____

Apt. No. (If applicable): _____

City, State, Zip Code: _____

Date of Birth: _____ Social Security No.: _____

Preferred Number: (please check one)

_____ Home Phone Number: _____

_____ Cell Phone Number: _____

Text Message Appointment Reminders? _____Yes _____No

_____ Work Phone Number: _____

Marital Status:

(please check one) _____SINGLE

_____MARRIED

_____WIDOWED

_____DIVORCED

Primary Care Physician: Dr. ***(First Name):*** _____ ***(Last Name):*** _____

Your Employer: _____

EMERGENCY CONTACT NAME: _____

Emergency Contact Ph. # _____ Relationship: _____

INSURANCE INFO:

Name of **INSURED SUBSCRIBER:** _____

Social Security No. (if other than yourself): _____

Date of Birth of **INSURED SUBSCRIBER** (if other than yourself)**:** _____

Relationship of **INSURED SUBSCRIBER** to Patient (if other than yourself): _____

E-MAIL ADDRESS: _____

_____*I would like to view/receive my lab results online through the secure Patient Portal*

**** The Federal Government requires us to ask the following items:***

*** RACE: (please check one)**

_____ AMERICAN INDIAN
_____ ASIAN
_____ BLACK OR AFRICAN AMERICAN
_____ HISPANIC OR LATINO
_____ NATIVE HAWAIIAN
_____ WHITE
_____ DECLINED
_____ OTHER
_____ UNKNOWN

*** ETHNICITY: (please check one)** _____HISPANIC _____NOT HISPANIC _____UNKNOWN _____DECLINED

*** LANGUAGE:** _____

Preferred Pharmacy Name: _____ Pharmacy Ph. #: _____

Pharmacy Location (*city and crossroads*): _____

Please note that services you receive on the date of service may not be payable by your insurance carrier. This includes charges from our office and a separate Lab charge. You will be held responsible for payment if your insurance carrier does not cover these charges.

Please Sign and Date: _____ Date: _____