

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: _____