

Eagles Landing OB/GYN

Revised 2/1/24

CONFIDENTIAL PATIENT INFORMATION SHEET

Name _____ Age _____ Date of Birth _____
Street Address _____ Apt/Unit _____
City _____ State _____ Zip _____ SS# _____
Cell Phone _____ Primary Phone _____
Race _____ Religion _____
Email Address _____
Emergency Contact _____ Phone _____
Relationship? _____
Primary Care Physician _____ Phone _____
Which doctor referred you to our office, if any? _____
Is patient a minor? Yes No
Please complete the following, we now send all prescriptions to your pharmacy electronically.
Name of Pharmacy _____ City _____
Road pharmacy is located on _____

INSURANCE INFORMATION

(Please present all insurance cards and picture ID at the front for photo copying)

Primary Insurance _____ Policy # _____ Group # _____
Policy Holder's Name _____ SS# _____ DOB _____
Secondary Insurance _____ Policy # _____ Group # _____
Policy Holder's Name _____ SS# _____ DOB _____

Release of Information Policies

I give my permission for Eagles Landing OBGYN to leave detailed messages on my voicemail/ answering machine. Yes No

I give permission for Eagles Landing OBGYN to discuss my medical and financial information with _____ who is my _____.

By signing below, I authorize Eagles Landing OBGYN to use and/ or disclose protected health information about me to the parties listed above.

Signature _____ Date _____

(Parent or Guardian if patient is a minor)