

Steamboat Springs Women's Clinic
Patient Information

Preferred Pharmacy: _____

Patient Name: _____ Preferred Name: _____

DOB: ____/____/____ SS#: ____-____-____ Marital Status: _____ DL#: _____

Address: _____ City: _____ State: ____ Zip: _____

Home Phone#: _____ Work Phone #: _____ Cell Phone #: _____

Preferred#? Y or N

Preferred#? Y or N

Preferred#? Y or N

OK to Leave Msg? Y or N

OK to Leave Msg? Y or N

OK to Leave Msg? Y or N

****By providing us with your land line or cell phone number(s), you give express authorization to contact you at those numbers. This express authorization also applies to any land line or cell phone number(s) you may acquire in the future. Phone calls to you may be made utilizing automated dialer technology. Providing your phone number(s) is not a condition of receiving our services.*

Email: _____

Employment

N/A

Name of Employer/School: _____ Phone #: _____

Address: _____ City: _____ State: ____ Zip: _____

Spouse/Partner

N/A

Spouse/Partner Name: _____ DOB: ____/____/____ SS#: ____-____-____

Spouse Employer: _____ Spouse Work/Cell#: _____

Address: _____ City: _____ State: ____ Zip: _____

Notify Spouse **FIRST** in Case of an Emergency

Emergency Contact ***Other Than Spouse Required

Name: _____ Relationship: _____

Home Phone#: _____ Work Phone #: _____ Cell Phone #: _____

Insurance Information

Primary Insurance Company: _____ Secondary Insurance Company: _____

Please Circle One In Each Category

Race: American Indian or Alaskan Native ~ Asian or Pacific Islander ~ Black ~ White ~ Hispanic

Ethnicity: Black, not Hispanic Origin ~ Black, Hispanic Origin ~ Hispanic Origin ~ White, Not Hispanic Origin

Patient's or Authorized Person's Signature:

I authorize the release of any medical or other information necessary to obtain payment for services rendered. I also authorize payment of medical benefits directly to the supplier of the medical services rendered.

Signature: _____ Date: _____