Carolina Gynecology, PA **Patient Information Sheet**

Personal information

Name: _____ Phone: Home _____

Address _____ Work _____

City _____Cell _____

State _____ Zip _____ SS # _____

DOB _____ Age _____ Marital Status _____

Emergency Contact/Relationship _____ Phone _____

Primary Care Physicians _____ Phone _____

How did you learn about us? Physician Friend Yellow Pages Ad on website

Pharmacy Preference

Name of Pharmacy _____ Phone _____

Insurance Information

Primary _____ Secondary _____

ID # _____ ID # _____

Phone # _____ Phone # _____

Name of Insured _____ Name of Insured _____

Insured's DOB/ Relationship _____ Insured's DOB/Relationship _____

Patient Consent

I hereby give my permission & consent for Carolina Gynecology & staff to treat me using generally accepted standards of medical care. I am aware that medicine & surgery are not exact sciences & no guarantee for successful outcome has been made or implied to me. I understand that treatment for my condition(s) will be based upon the information that I provide. I accept full responsibility should I provide inaccurate, incomplete, or misleading information. I certify that the identifying information, address, and telephone information I have provided is correct and agree to inform Carolina Gynecology if such information changes or becomes outdated. I understand that Carolina Gynecology & staff cannot contact me if I provide incorrect or illegible information should I not keep this information current and correct. There is a $40 fee for all non-kept appointments without 24 hours of prior notice. I hereby acknowledge that I am responsible for full payment of services rendered within 90 days.

Patient's Printed Name _____

Patient's Signature _____

Date_____

Responsible Party's Signature _____