Date:_____

Patient Information

Patient Name: (Last, First, M.I.)_____

Date of Birth:_____ SS#:_____

Address:_____

Home Phone:_____ Cell:_____

Email Address:_____

Do we have permission to leave Detailed Information messages on your email and / or phone?
YES or NO

Primary Care Doctor:_____ Office Phone:_____

Please circle one: Minor Single Married Divorced Separated Widowed

Employment Status: Full Time Part Time Unemployed Retired Student

Occupation:_____ Employer:_____

Employers Address:_____ Work Phone:_____

Emergency Contact:_____ Relationship:_____

Address:_____ Phone:_____

Release of Liability

I hereby give permission to the person (s) listed below to receive information about the care of the above-named patient.

Name	Phone Number	Relationship

I authorize the provider to release any information to process insurance claims.

I have read the "Notice of Information Practices" for Helva Gynecology & Infertility Associates, PC. I understand how my medical information may be used and disclosed, and how I can get access to this information.

Gynecology & Infertility Associates reserves the right to charge a $60.00 no show fee for all confirmed appointments.

Patient / Guardian Signature:_____