

PATIENT INFORMATION

NAME (last) _____ (first) _____ (middle) _____
ADDRESS _____ CITY, STATE _____
ZIP +4 _____ + _____ E-Mail _____
BIRTHDATE ____ / ____ / ____ SS# _____ - _____ - _____ MARITAL STATUS _____

HOME PHONE _____ OCCUPATION _____
WORK PHONE _____ NEW TO DR. RUSSELL? YES ____ NO ____
CELL PHONE _____ REFERRED BY _____

IN CASE OF EMERGENCY

CONTACT _____ RELATION TO PT _____
CELL PHONE _____ HOME PHONE _____

PRIMARY INSURANCE - COMPLETE ALL INFORMATION

NAME OF INSURED _____ M () F () INSURED SS# ____ / ____ / ____
RELATION TO PT _____ INSURED BIRTHDATE ____ / ____ / ____
INSURED WORK PHONE _____ EMPLOYER _____
EXT. _____ INSURANCE COMPANY _____
ID # _____ GROUP # _____

SECONDARY INSURANCE - IF ANY

NAME OF INSURED _____ M () F () INSURED SS# ____ / ____ / ____
RELATION TO PT _____ INSURED BIRTHDATE ____ / ____ / ____
INSURED WORK PHONE _____ OCCUPATION _____
EXT. _____ INSURANCE COMPANY _____
ID # _____ GROUP # _____

RESPONSIBLE PARTY IF DIFFERENT FROM POLICY HOLDER

NAME _____ DATE OF BIRTH ____ / ____ / ____
ADDRESS _____ S S # ____ / ____ / ____
_____ RELATIONSHIP _____

IF PATIENT IS A MINOR (UNDER 18), PLEASE LIST THE PARENT OR GUARDIAN'S NAME:

PARENT OR GUARDIAN'S BIRTHDATE _____ / _____ / _____ AND SIGNATURE

TODAY'S DATE _____

PT CHART

DR. CAROL M. RUSSELL OB / GYN