AZALEA GYNECOLOGY
736 Medical Center Drive, Suite 102
Wilmington, NC 28401
910-452-3666

www.azaleagyn.com

PATIENT ACCT NO:

PATIENT DEMOGRAPHIC WORKSHEET

PATIENT

PATIENT NAME	MARITAL STATUS	DATE OF BIRTH	SEX	AGE	RACE

STREET ADDRESS	APT/SUITE#/PO Box #

City	STATE	ZIP	SSN

PATIENT HOME PHONE	EMERGENCY CONTACT	EMERGENCY CONTACT PHONE

PATIENT EMPLOYER/SCHOOL NAME	PATIENT OCCUPATION (IF STUDENT, INDICATE FULL TIME OR PART TIME)	PATIENT WORK PHONE

PATIENT EMAIL ADDRESS	REFERRED TO THIS PRACTICE BY:	PATIENT MOBILE PHONE

RESP PARTY

RESP PARTY NAME	RELATIONSHIP TO PATIENT	RESP PARTY HOME PHONE

STREET ADDRESS	APT/SUITE #

City	STATE	ZIP CODE	RESP PARTY MOBILE PHONE

INSURANCE INFORMATION

INSURANCE

PRIMARY INSURANCE	EFFECTIVE DATE	ID /GROUP NUMBER	

POLICY HOLDER NAME	RELATIONSHIP TO INSURED	POLICY HOLDER DATE OF BIRTH	POLICY HOLDER SOCIAL SECURITY NUMBER

POLICY HOLDER EMPLOYER NAME

SECONDARY INSURANCE	EFFECTIVE DATE	ID / GROUP NUMBER	

POLICY HOLDER NAME	RELATIONSHIP TO INSURED	POLICY HOLDER DATE OF BIRTH	POLICY HOLDER SOCIAL SECURITY NUMBER

POLICY HOLDER EMPLOYER NAME

PHARMACY NAME AND LOCATION	PHARMACY PHONE NUMBER

AUTHORIZATION & CONSENT

CONSENT

I HEREBY AUTHORIZE THIS PRACTICE TO RELEASE INFORMATION TO MY INSURANCE COMPANY. I ALSO AUTHORIZE THIS PRACTICE TO RELEASE MY MEDICAL INFORMATION, INCLUDING PRIVILEGED, SENSITIVE INFORMATION, TO ANY HOSPITAL, PHYSICIAN OR PROVIDER THIS OFFICE AND MY PRIMARY CARE PHYSICIAN MAY REFER ME TO. I AUTHORIZE PAYMENT OF MEDICAL BENEFITS DIRECTLY TO THE PHYSICIAN AND I AUTHORIZE THE USE OF THIS SIGNATURE ON ALL INSURANCE CLAIMS FORMS. I AUTHORIZE A COPY OF THIS AUTHORIZATION TO BE USED IN PLACE OF THE ORIGINAL.

SIGNED: _____ **DATE:** _____