Athens Women's Clinic
817 Cook Drive
Athens, TN 37303
Phone: (423) 745-3394 Fax: (423) 745-6779

PATIENT INFORMATION SHEET

Date _____ E-mail address _____@ _____._____

Name _____ Maiden _____
Last First Middle

Date of Birth _____ / _____ / _____ Age _____ SSN _____ - _____ - _____

Sex ❑ Male ❑ Female Race _____ Ethnicity _____

Check appropriate box ❑ Minor ❑ Single ❑ Married ❑ Divorced ❑ Separated ❑ Widowed ❑ Other

Home (_____) _____- _____ Work Phone (_____) _____ - _____ Cell Phone (_____) _____ - _____

Address _____ County _____

City _____ State _____ Zip _____

Employer _____ Occupation _____

Primary Care Physician _____ Physician's Phone (_____) _____ - _____

Spouse or Parent Name _____ Employer _____

Cell Phone (_____) _____ - _____ Work Phone (_____) _____ - _____

Emergency Contact _____ Relationship _____

Cell Phone (_____) _____ - _____ Other Phone (_____) _____ - _____

Preferred Pharmacy Name _____ Phone (_____) _____ - _____

Address _____ City, State _____

Insurance Company _____

Policy Holder _____ Policy Holder's SSN _____ - _____ - _____

Policy Number _____ Group Number _____

I hereby authorize the certified providers of Athens Women's Clinic, PC to provide obstetrical and gynecological care for me or my dependent. I give the providers permission to perform any necessary procedures and / or treatment after reviewing and explaining the procedure(s) and the associated risks.

X_____ _____
Patient or Guardian signature Date