

PATIENT INFORMATION  
**PIEDMONT HEALTHCARE FOR WOMEN, P.A.**  
GREENSBORO OB-GYN ASSOCIATES DIVISION

(Please Print)

1. Patient # \_\_\_\_\_  
2. Patient Name \_\_\_\_\_ 4. Date of Birth \_\_\_\_\_  
5. Social Security# \_\_\_\_\_ 6. Doctor \_\_\_\_\_  
12. Address \_\_\_\_\_ 14. Home Phone (\_\_\_\_) \_\_\_\_\_  
\_\_\_\_\_ 15. Work Phone (\_\_\_\_) \_\_\_\_\_

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20. Insurance Company#1 \_\_\_\_\_ Employer \_\_\_\_\_  
21. Policyholder Name \_\_\_\_\_ 23. Date of Birth \_\_\_\_\_  
24. Social Security # \_\_\_\_\_  
25. Relationship to Policyholder: Self \_\_\_\_\_ Spouse \_\_\_\_\_ Child \_\_\_\_\_ Dependent \_\_\_\_\_

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40. Insurance Company #2 \_\_\_\_\_ Employer \_\_\_\_\_  
41. Policy Holder Name \_\_\_\_\_ 43. Date of Birth \_\_\_\_\_  
44. Social Security # \_\_\_\_\_  
45. Relationship to Policyholder: Self \_\_\_\_\_ Spouse \_\_\_\_\_ Child \_\_\_\_\_ Dependent \_\_\_\_\_

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79. Marital Status \_\_\_\_\_ Family Doctor \_\_\_\_\_  
Emergency Contact Person and Phone # \_\_\_\_\_

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AUTHORIZATION TO RELEASE INFORMATION: I hereby authorize the release of medical information and/or photographs to my specified insurance carriers or individuals having just cause to request such information. I authorize direct payment of surgical and medical benefits to Piedmont Healthcare for Women, P.A./Greensboro OB-GYN Associates Division. Confidentiality will be honored and the original medical records and/or photographs will remain a part of the office medical record.

Signature \_\_\_\_\_ Date \_\_\_\_\_  
(If Minor, Parent or Guardian)