South Florida Women's Care
Obstetrics and Gynecology
8950 SW 74th Ct, Suite 2001
Miami, FL 33156
Office 305-661-7760
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Lucia Gaitan, MD, FACOG
Ester Avero, PA-C

PATIENT / GUARANTOR DEMOGRAPHIC INFORMATION

PERSONAL INFORMATION:

Name: _____ Date of Birth: _____/_____/_____

Social Security Number: _____ Mobile Phone #: (_____) _____-_____

Address: _____City: _____State: _____Zip: _____

Email: _____@_____**.com**

Primary Care Physician Name: _____ Phone #_____

Employer _____

_____ _____
Patient/Guarantor Signature **Date**

INSURANCE INFORMATION:

Primary Ins. Co.: _____ ID/Subscriber #: _____

Relationship to Insured: Self _____ Spouse _____ Dependent _____

If other than self; Insured Name/DOB: _____ DOB: _____/_____/_____

Secondary/Supp. Ins. Company: _____ ID/Subscriber #: _____

EMERGENCY CONTACT:

Name: _____ Relationship: _____

Mobile Phone #: (_____) _____-_____
Please make sure to add emergency contact to HIPAA form if you would like to have your Personal Health Information disclosed and shared

ALLERGIES & CURRENT MEDICATIONS:

Allergies: _____

Medications: _____

Pharmacy Name: _____ Phone #: (_____) _____-_____