

**South Florida Women's Care
Obstetrics and Gynecology**

8950 SW 74th Ct, Suite 2001
Miami, FL 33156
Office 305-661-7760 Fax 786-558-4496



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PATIENT / GUARANTOR DEMOGRAPHIC INFORMATION

PERSONAL INFORMATION:

Name: _____ **Date of Birth:** ____/____/____

Last four Social Security Number: _____ Mobile Phone #: (____) ____--____

Address: _____ City: _____ State: _____ Zip: _____

Email: _____

Employer _____ Phone Number: _____

Primary Care Physician Name: _____ Phone # _____

Last Physical / Wellness Exam date: _____ *Provider Name:* _____

Patient/Guarantor/Legal Guardian 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 (No access to Personal Health Information unless added to HIPAA FORM)

Name: _____ Relationship: _____

Mobile Phone #: (____) ____-____

ALLERGIES & CURRENT MEDICATIONS:

Allergies: _____

Medications: _____

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