# *Durham Women's Center*
# NEW PATIENT FORM

*Date*_____

*Name*_____
*Date of Birth*_____*Age*_____*Marital Status*_____
*Address*_____
*City*_____*State*_____*Zip*_____
*Phone (  )*_____ *Cell or Pager*_____
*Social Security #*_____*Occupation*_____
*Employer* _____
*Work Phone(  )* _____
*Spouse name*_____*Employer*_____
*Spouse SocSec#*_____*Spouse Date of Birth* _____
*Referred by*_____
*Medical Insurance Co.*_____
*ID#*_____ *Group #* _____
***Policyholder*** _____ *DOB:* _____
***Emergency contact and phone #***_____
***Phone number for confidential results***_____

*Have you seen this doctor previously* _____
*Are you pregnant?*_____*Last menstrual period started*_____
*Using Contraception*_____
*Last pap smear date and result*_____
*List any Allergies to Medication*_____
*Medications taken daily/weekly* _____
_____

***What pharmacy would you like us to use if we need to call in medication:***

_____ ***Phone #*** _____

*Reason for visit today* _____

*Authorization to release information. I authorize the release of any medical information necessary to process any claims. I permit a copy of this authorization to be used in the place of the original.*
*Signature*_____*Date*_____

*Authorization for payments. I authorize payment of any medical benefits payable to Durham Women's Center for any service rendered. I understand that I am financially responsible to Durham Women's Center for charges not covered by this authorization.*
Signature_____Date_____