SIOUXLAND Obstetrics Gynecology P.C.
"Providing a lifetime of health care for women"

*Paul J. Eastman, M.D.*
*Tauhni T. Hunt, M.D.*
*Angela J. Aldrich, M.D.*
*Melissa N. Holtz, M.D.*
*Hannah I. Dewald, M.D.*

## WELCOME

Thank you for selecting our healthcare team! We will strive to provide you with the best possible health care.
To help us meet all your healthcare needs, **PLEASE FILL OUT THIS FORM COMPLETELY IN BLACK OR BLUE INK.**
If you have any questions or need assistance, please ask us – we will be happy to help.

## Personal Information

(PLEASE PRINT)

Name _____ Birthdate _____ Age _____
First Middle Last

Address _____ City _____ State _____ Zip _____

Home phone ( _____ ) _____ - _____ Social Security # _____ - _____ - _____

Cell phone ( _____ ) _____ - _____ Email Address _____

Marital Status (circle) Married Single Divorced Separate Widow

Preferred method of contact (circle) Home Cell Work

Language best served _____ Race (circle) White American Indian Asian Black Unlisted

Ethnicity (circle) Hispanic/Latino Not Hispanic/Latino Decline to Answer

Your Employer _____ Work# ( _____ ) ( _____ ) – ( _____ ) ext _____

Referring Doctor _____ Phone # _____ Pharmacy _____

Family Doctor _____ Phone # _____

## Insurance Information

Policy Holder _____ DOB _____ Self Spouse Parent

Policy Holder's Employer _____

## Authorization and Release

I understand that I am financially responsible to pay Siouxland Obstetrics & Gynecology, PC its usual charges for all services received through the office including any balances such as co-pays, deductibles, non-covered services, co-insurances and items considered not medically necessary from my insurance company. I hereby assign any and all insurance proceeds, otherwise payable to me, for coverage(s) provided by my health insurance carrier to Siouxland Obstetrics & Gynecology, PC and direct that payment be made directly to the office. I authorize the release of any medical information necessary to process the claim.

X _____
Signature of patient or parent if minor Date

SIOUXLAND Obstetrics Gynecology P.C.
"Providing a lifetime of health care for women"

*Paul J. Eastman, M.D.*
*Tauhni T. Hunt, M.D.*
*Angela J. Aldrich, M.D.*
*Melissa N. Holtz, M.D.*
*Hannah I. Dewald, M.D.*

**Contacts/Communication:**

(please list anyone we may contact or speak to about your healthcare)

| | Release of Medical Records | Primary Contact | Legal Guardian | Emergency Contact |
|---|---|---|---|---|
| Spouse _____ | ☐ | ☐ | ☐ | ☐ |
| Phone Number _____ | | | | |
| Parent _____ | ☐ | ☐ | ☐ | ☐ |
| Phone Number _____ | | | | |
| Emergency Contact _____ | ☐ | ☐ | ☐ | ☐ |
| Phone Number _____ Relationship _____ | | | | |
| Other Contact _____ | ☐ | ☐ | ☐ | ☐ |
| Phone Number _____ Relationship _____ | | | | |

When contacting you by phone, may we leave a message on an answering machine to return our call?

_____ Yes _____ No

via text messaging for reminder appointments _____ yes _____ no

if no, please list preferred method _____

Signature of patient
or parent if minor _____ Date _____

*2730 Pierce Street, Suite 201 • Sioux City, Iowa 51104*
*Phone (712) 277-3141 • Fax (712) 277-2645 • www.siouxlandobgyn.com*

POS Reorder # 1306780