

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 _____

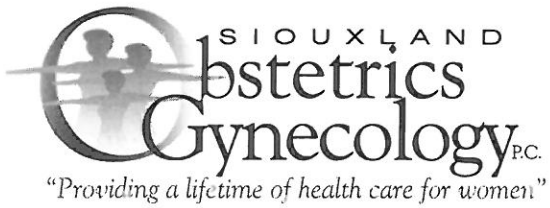
Authorization and Release

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



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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 _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Parent _____ Phone Number _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Emergency Contact _____ Phone Number _____ Relationship _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other Contact _____ Phone Number _____ Relationship _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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 _____