

Dear Patient:

Welcome to our office! We look forward to participating in your medical care. To assist you in receiving care, we would like to acquaint you with our office policies.

Our office hours are Monday through Friday, 8:00 a.m. – 5:00 p.m. If you have an EMERGENCY situation after office hours, telephone our office at 533-0348 for recorded information about the doctor on call.

Please notify our office at least 24 hours in advance if you are unable to keep your scheduled appointment. Please do not bring young children with you to your initial appointment.

You can read our payment policy that explains our billing and collection policies under the insurance and payment section of our website. Please review it before your visit and keep it for future reference.

We have enclosed our patient demographic form that you should complete and return to our office before your appointment. This will allow us to enter most of your personal and insurance information into our computer and avoid delays the day of your appointment. It would be helpful if you could also send a copy of the front and back of your CURRENT insurance card.

Sincerely,

Fairhaven OB/GYN and Staff

DATE \_\_\_\_\_ YOUR COMPLETE LEGAL NAME \_\_\_\_\_  
SINGLE \_\_\_\_\_ MARRIED \_\_\_\_\_ WIDOWED \_\_\_\_\_ DIVORCED \_\_\_\_\_  
AGE \_\_\_\_\_ DATE OF BIRTH \_\_\_\_\_ RACE \_\_\_\_\_ HOME PHONE \_\_\_\_\_  
ADDRESS \_\_\_\_\_  
CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP CODE \_\_\_\_\_  
YOUR PLACE OF EMPLOYMENT \_\_\_\_\_ CITY \_\_\_\_\_  
EMPLOYMENT ADDRESS \_\_\_\_\_ EMPLOYMENT PHONE \_\_\_\_\_  
YOUR SOCIAL SECURITY # \_\_\_\_\_

YOUR HUSBAND'S LEGAL NAME \_\_\_\_\_  
HUSBAND'S SOCIAL SECURITY # \_\_\_\_\_ HUSBAND'S DATE OF BIRTH \_\_\_\_\_  
YOUR HUSBAND'S PLACE OF EMPLOYMENT \_\_\_\_\_ CITY \_\_\_\_\_  
HUSBAND'S EMPLOYMENT ADDRESS \_\_\_\_\_ EMPLOYMENT PHONE \_\_\_\_\_

IF SINGLE, ARE YOU LIVING WITH YOUR PARENTS? MOTHER \_\_\_\_\_ FATHER \_\_\_\_\_  
PARENT'S NAMES \_\_\_\_\_  
FATHER'S EMPLOYMENT \_\_\_\_\_ FATHER'S SOCIAL SECURITY # \_\_\_\_\_  
MOTHER'S EMPLOYMENT \_\_\_\_\_ MOTHER'S SOCIAL SECURITY # \_\_\_\_\_

LIST PERSON TO NOTIFY IN CASE OF EMERGENCY:  
NAME \_\_\_\_\_ ADDRESS \_\_\_\_\_  
PHONE # DAY \_\_\_\_\_ NIGHT \_\_\_\_\_ RELATIONSHIP TO YOU \_\_\_\_\_

NEAREST RELATIVE NOT LIVING IN YOUR HOUSEHOLD:  
NAME \_\_\_\_\_ ADDRESS \_\_\_\_\_  
PHONE # DAY \_\_\_\_\_ NIGHT \_\_\_\_\_ RELATIONSHIP TO YOU \_\_\_\_\_

YOUR FAMILY PHYSICIAN \_\_\_\_\_  
DID A DOCTOR REFER YOU HERE? \_\_\_\_\_ DOCTOR'S NAME \_\_\_\_\_

DO YOU HAVE INSURANCE COVERAGE? YES \_\_\_\_\_ NO \_\_\_\_\_

**PLEASE SHOW US YOUR CARD AS WE NEED TO MAKE A COPY**

ARE YOU COVERED UNDER:

YOUR HUSBAND'S POLICY? YES \_\_\_\_\_ NO \_\_\_\_\_ POLICY # \_\_\_\_\_  
IS IT A GROUP INS. PLAN AT WORK? \_\_\_\_\_ PERSONAL INS. PLAN? \_\_\_\_\_  
YOUR OWN POLICY? YES \_\_\_\_\_ NO \_\_\_\_\_ POLICY # \_\_\_\_\_  
IS IT A GROUP INS. PLAN AT WORK? \_\_\_\_\_ PERSONAL INS. PLAN? \_\_\_\_\_  
IF SINGLE, YOUR PARENT'S POLICY? FATHER'S \_\_\_\_\_ MOTHER'S \_\_\_\_\_  
PARENT'S POLICY # \_\_\_\_\_  
NAME OF PARENT INSURED AND PLACE OF THEIR EMPLOYMENT \_\_\_\_\_

**PLEASE SHOW US YOUR MEDICAID OR MEDICARE CARDS IF YOU ARE COVERED UNDER EITHER PLAN**

IF YOU ARE ON MEDICAID PLEASE INDICATE YOUR MEDICAID NUMBERS \_\_\_\_\_  
IF YOU ARE ON MEDICARE PLEASE INDICATE YOUR MEDICARE NUMBERS \_\_\_\_\_  
DO YOU HAVE A MEDICARE SUPPLEMENT? YES \_\_\_\_\_ NO \_\_\_\_\_  
WHAT IS THE NAME OF YOUR SUPPLEMENT? \_\_\_\_\_

HAVE YOU PREVIOUSLY SEEN OUR DOCTORS? YES \_\_\_\_\_ NO \_\_\_\_\_  
HAVE YOU SEEN OUR DOCTORS PREVIOUSLY IN OUR OFFICE OR DID YOU SEE THEM IN THE  
HOSPITAL? \_\_\_\_\_ WHAT YEAR DID YOU SEE OUR DOCTORS? \_\_\_\_\_  
PLEASE LIST ANY PREVIOUS NAMES YOU HAVE HAD \_\_\_\_\_