

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

Fairhaven Obstetrics & Gynecology, Inc.  
1111 Lighthouse Lane, Goshen, IN. 46526

www.fairhavenobgyn.org  
Phone: (574) 533-0348

PLEASE PRINT

DATE \_\_\_\_\_ YOUR COMPLETE LEGAL NAME \_\_\_\_\_

SINGLE \_\_\_ MARRIED \_\_\_ WIDOWED \_\_\_ DIVORCED \_\_\_ AGE \_\_\_\_\_ DATE OF BIRTH \_\_\_\_\_ RACE \_\_\_\_\_

CONTACT PHONE # \_\_\_\_\_ ALTERNATE PHONE # \_\_\_\_\_

SOCIAL SECURITY # \_\_\_\_\_ ADDRESS \_\_\_\_\_

CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP CODE \_\_\_\_\_

E-MAIL \_\_\_\_\_ PLACE OF EMPLOYMENT \_\_\_\_\_

EMPLOYMENT ADDRESS \_\_\_\_\_ EMPLOYMENT PHONE \_\_\_\_\_

**HOW DO YOU PREFER WE CONTACT YOU? (PLEASE CHECK ONE)** E-MAIL \_\_\_ WORK \_\_\_ PHONE \_\_\_

HUSBAND'S LEGAL NAME \_\_\_\_\_

HUSBAND'S SOCIAL SECURITY # \_\_\_\_\_ HUSBAND'S DATE OF BIRTH \_\_\_\_\_

HUSBAND'S PLACE OF EMPLOYMENT \_\_\_\_\_ CITY \_\_\_\_\_

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

**IF YOU ARE COVERED UNDER YOUR PARENTS INSURANCE PLEASE PROVIDE THE FOLLOWING:**

MOTHER'S NAME \_\_\_\_\_ FATHER'S NAME \_\_\_\_\_

MOTHER'S EMPLOYMENT \_\_\_\_\_ FATHER'S EMPLOYMENT \_\_\_\_\_

MOTHER'S SOCIAL SECURITY # \_\_\_\_\_ FATHER'S SOCIAL SECURITY # \_\_\_\_\_

MOTHER'S DATE OF BIRTH \_\_\_\_\_ FATHER'S DATE OF BIRTH \_\_\_\_\_

**LIST PERSON(S) TO NOTIFY IN CASE OF EMERGENCY:**

NAME \_\_\_\_\_ ADDRESS \_\_\_\_\_

PHONE # DAY \_\_\_\_\_ NIGHT \_\_\_\_\_ RELATIONSHIP TO YOU \_\_\_\_\_

NAME \_\_\_\_\_ ADDRESS \_\_\_\_\_

PHONE # DAY \_\_\_\_\_ NIGHT \_\_\_\_\_ RELATIONSHIP TO YOU \_\_\_\_\_

YOUR FAMILY PHYSICIAN \_\_\_\_\_

HAVE YOU PREVIOUSLY SEEN OUR DOCTORS IN THE HOSPITAL OR IN THE OFFICE? \_\_\_\_\_

PLEASE LIST ANY PREVIOUS NAMES YOU HAVE HAD \_\_\_\_\_

HOW DID YOU HEAR ABOUT FAIRHAVEN? \_\_\_\_\_

**PLEASE PRESENT PHOTO I.D. WITH CURRENT ADDRESS &**