TRINITY UROGYNECOLOGY

WESLEY CHAPEL UROGYNECOLOGY

NEW PATIENT FORM

First Name: _____ MI: _____ **Last Name:** _____

Date of Birth: _____ Sex: [ ] Female [ ] Male

Ethnicity: White/ African American/Asian/Hispanic/Native American/Native Hawaiian/Other/Do not disclose

Home Address: _____

City:_____ State: _____ Zip Code: _____

Home Phone: _____ Cell Phone: _____

Email: _____ Can we contact you by text or email notifications? [ ] Yes [ ] No

Emergency contact: _____ **Phone:** _____ **Relation:**_____

PHARMACY INFORMATION

Pharmacy name: _____ **Phone:** _____

Pharmacy address: _____

MailOrder Pharmacy: _____ Address: _____

Mail Order Pharmacy Phone Number: _____

PRIMARY CARE PHYSICIAN

Primary Care Physician: _____

Phone #: _____ Fax #: _____

Address: _____ City: _____ State: _____

Zip Code: _____

RELEASE AND ASSIGNMENT

The information that I have given above is correct to the best of my knowledge. I understand that it will be held in strict confidence and it is my responsibility to notify the office of any changes to the information provided immediately. I hereby assign all insurance benefits directly to Trinity Urogynecology and Associates, PLLC for services rendered. I understand that I am financially responsible for all charges whether or not paid by the insurance company. I hereby authorize the practice to release all information necessary to secure the payment of benefits. I also authorize the practice to release all information necessary to secure the payment of benefits. I also authorize the practice to release all external prescription history as required by law. I permit the use of my signature on all insurance submissions whether electronic or paper.

_____ _____

Patient/Guardian Signature **Today's Date**