South Shore Women's Health Care

2690 S. Cleveland Avenue
Saint Joseph, MI 49085

Patient Name ______________________________ Date ______________
Address ______________ City ______________ State ________ Zip ________
Employer ______________________ Occupation ______________________
Driver's License # ______________________ Social Security # ______________________
Date of Birth ______________________ Marital Status M S W Sep D

Spouse Name ______________________________ Date of Birth ______________
Employer ______________ Occupation ______________ Work Phone ______________
Spouse Social Security # ______________________

Primary Insurance ______________________ Effective ______________________
Policy Holder ______________________ Relationship to You ______________________
Policy Holder Date of Birth ______________________ Policy Holder Social Security # ______________________
Secondary Insurance ______________________ Effective ______________________
Policy Holder ______________________ Relationship to You ______________________

Primary Care physician you have listed with your insurance carrier ______________________
Whom may we thank for referring you to our practice? ______________________

TELEPHONE NOTIFICATION CONSENT

Due to our concern for your confidentiality, we are asking that you sign a release to advise us how we may contact you. **Please select one or more options**.

I give permission for office staff to call and identify themselves as calling from South Shore Women's Health Care and leave detailed information regarding my appointment schedule, test results, prescriptions or care on my answering machine:

- ☐ At Home # ______________
- ☐ At Work # ______________
- ☐ Cell Phone # ______________
- ☐ Do not phone me. I understand I will receive all (urgent and non-urgent) notifications and reminders by mail only.

I also give permission for office staff to speak with the following individual(s):

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Signed______________________________Date__________