BLESSINGS
Woman's Care & Medical Spa
7157 University Blvd.,
Winter Park, FL 32792
(407) 571-9185

PATIENT INFORMATION SHEET

PATIENT LAST NAME	FIRST	M.I	SOCIAL SECURITY NO.		
ADDRESS	CITY	STATE	ZIP		
DATE OF BIRTH	PRIMARY PHONE ( )	WORK PHONE ( )	CELL PHONE ( )		
MARITAL STATUS ☐ Single ☐ Married ☐ Other	WORK STATUS ☐ Employed ☐ Other ☐ PT Student ☐ FT Student	DRIVERS LICENSE NO.	PHARMACY, PHARMACY PHONE , LOCATION ( )		
NEAREST RELATIVE NOT LIVING IN HOUSEHOLD	RELATIONSHIP	PHONE ( )			
ADDRESS	CITY	STATE	ZIP		
PATIENT EMAIL					
PRIMARY CARE PHYSICAN	ADDRESS	PHONE ( )			

EMPLOYMENT				
EMPLOYERS NAME	OCCUPATION			
ADDRESS	CITY	STATE	ZIP	
WORKMANS COMP INJURY YES NO	SUPERVISORS NAME	EMPLOYER I.D.		

INSURANCE INFORMATION				
PRIMARY INSURANCE	POLICY NO.	GROUP NO.	RELATIONSHIP TO INSURED ☐ Self ☐ Spouse ☐ Child ☐ Other	
ADDRESS	CITY	STATE	ZIP	
SECONDARY INSURANCE	POLICY NO.	GROUP NO.	RELATIONSHIP TO INSURED ☐ Self ☐ Spouse ☐ Child ☐ Other	
ADDRESS	CITY	STATE	ZIP	
RESPONSIBLE PARTY (If different from patient)	PRIMARY PHONE ( )	WORK PHONE ( )	CELL PHONE ( )	
ADDRESS	CITY	STATE	ZIP	
DATE OF BIRTH	SOCIAL SECURITY NO.	EMPLOYER		

PLEASE TELL US HOW YOU WERE REFERED TO US

☐ PHYSICIAN (NAME) _____ ☐ FRIEND (NAME)_____

☐ INTERNET ☐ INSURNACE ☐ OTHER _____

ASSIGNMENT OF BENEFITS/RELEASE OF INFORMATION

I hereby assign all Insurance benefits to which I am entitled, including Medicare, Medicaid, private insurance, major medical benefits and any other health plans to the assigned physician. The assignment will remain in effect until revoked by me in writing. I understand that I am financially responsible for all charges whether or not paid by said insurance. I also acknowledge receipt of the office privacy notice and financial agreements.

Patient or Responsible Party: _____ Date: _____

RELEASE OF PERSONAL INFORMATION

I authorize OB/GYN Care Group to discuss my: ☐ medical information, ☐ insurance/financial information, ☐ all information, with the following:

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

Patient: _____ Date: _____

EMERGENCY CONTACT

Name: Relationship: Phone: