Fair Oaks Women's Health
Convenience • Caring • Cutting-Edge

PATIENT INFORMATION FORM

Please take a few minutes to complete this form. There may be times when it is urgent that we contact you, so please try to be as complete and accurate as possible, especially with phone numbers. Thank you very much. All information provided is completely confidential.

DATE TODAY _____

LAST NAME _____ FIRST NAME _____ M.I. ____

PREFERRED FIRST NAME _____ DATE OF BIRTH _____ SSN# _____

ADDRESS _____ (PO Boxes Not Allowed)

CITY _____ STATE _____ ZIP _____

HOME PH# _____ MOBILE PH# _____ WORK PH# _____

PREFERRED Ph# WEEKDAYS (**CIRCLE** ONE): **HOME** **MOBILE** **WORK**

EMAIL _____ PREFERRED CONTACT METHOD: _____

MARITAL STATUS _____ DRIV LIC. # _____

Optional - We invite you to share your race, ethnicity, sexual orientation, and gender identity information:

RACE _____ ETHNICITY _____

SEXUAL ORIENTATION _____ GENDER IDENTITY _____

SEX AT BIRTH _____ PRONOUN ___she/her ___they/them ___he/him

Are you employed? _____ If yes, YOUR OCCUPATION _____

EMPLOYER NAME _____ PH.# _____

ADDRESS _____

CITY _____ STATE _____ ZIP _____

(If you are married/committed, may we have your spouse/sig other information)

SPOUSE/SIG OTHER NAME _____ DATE OF BIRTH _____

EMPLOYER _____ OCCUPATION _____

MOBILE PH# _____ WORK PH# _____

HOW DID YOU HEAR OF US? _____

WHO IS YOUR PRIMARY CARE DR. (PCP)? _____

PHARMACY NAME AND ADDRESS _____

PHARMACY CITY,STATE,ZIP _____ PH# _____

EMERGENCY CONTACT NAME _____ RELN _____

MOBILE PH# _____ OTHER PH# _____

Please sign below if you give us permission to message you (such as test results) via voice mail or e-mail:

SIGNED _____ DATE _____