

# New Patient Information Form

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Name: \_\_\_\_\_ Home Phone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Soc. Security No. #: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Work Phone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Home Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_ Zip: \_\_\_\_\_ Country: \_\_\_\_\_

Driver's License #: \_\_\_\_\_ Single  Married  Divorced  Widowed  Separated

Employer: \_\_\_\_\_ E-Mail Address: \_\_\_\_\_

Employer Address: \_\_\_\_\_ Occupation: \_\_\_\_\_

Spouse's Name: \_\_\_\_\_ Spouse's Occupation: \_\_\_\_\_

Spouse's Employer: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Parent or Guardian Name: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Nearest relative not living with you: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Nearest friend not living with you: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Primary Care Physician: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Who may we contact in case of an emergency?: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Who may we thank for referring you to us?: \_\_\_\_\_

Who is financially responsible for this bill?: \_\_\_\_\_

I will be paying by: CASH  CHECK  CREDIT CARD #: \_\_\_\_\_ Exp Date: \_\_/\_\_/\_\_\_\_

Primary Insurance: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Insurance Co. Address: \_\_\_\_\_

Insured's Name: \_\_\_\_\_ D.O.B.: \_\_/\_\_/\_\_\_\_ Relationship to you?: \_\_\_\_\_

Insured's SS#: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Policy #: \_\_\_\_\_ Group #: \_\_\_\_\_

Secondary Insurance: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Insurance Co. Address: \_\_\_\_\_

Insured's Name: \_\_\_\_\_ D.O.B.: \_\_/\_\_/\_\_\_\_ Relationship to you?: \_\_\_\_\_

Insured's SS#: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Policy #: \_\_\_\_\_ Group #: \_\_\_\_\_

I have read all the information on this sheet and have completed the above answers. I certify this information is true and correct to the best of my knowledge. Patients are not discriminated against in the delivery of healthcare services based on race, ethnicity, national origin, religion, sex, age, mental or physical disability, sexual orientation, genetic information or source of payment. Permission is also given to the physician for consultation, care and treatment.

Parent's/guardian's signature: \_\_\_\_\_ Date: \_\_/\_\_/\_\_\_\_

(\_\_\_\_) INITIAL I have reviewed the Notice of Privacy Practices for Nevada Women's Care.

(\_\_\_\_) INITIAL I have requested and received a copy of the Notice of Privacy Practices for Nevada Women's Care.