

**BRICK WOMEN'S PHYSICIANS, P.C.**  
**COMPLETE OB/GYN CARE**  
**Please Print Out and Sign Completed Form**

NAME \_\_\_\_\_ DATE \_\_\_\_\_

ADDRESS \_\_\_\_\_ CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_

HOME PHONE \_\_\_\_\_ WORK PHONE \_\_\_\_\_ CELL PHONE \_\_\_\_\_

DATE OF BIRTH \_\_\_\_\_ SS# \_\_\_\_\_ MARITAL STATUS S M D W

EMPLOYER NAME AND ADDRESS \_\_\_\_\_

**E-mail Address** \_\_\_\_\_

**Local Pharmacy Name & Address:** \_\_\_\_\_

**PRIMARY INSURANCE:** INSURED'S NAME \_\_\_\_\_ DATE OF BIRTH \_\_\_\_\_

SS# \_\_\_\_\_ RELATIONSHIP: SELF SPOUSE PARENT OTHER

NAME OF INSURANCE PLAN \_\_\_\_\_

ID# \_\_\_\_\_ GROUP # \_\_\_\_\_

**SECONDARY INSURANCE:** INSURED'S NAME \_\_\_\_\_ DATE OF BIRTH \_\_\_\_\_

SS# \_\_\_\_\_ RELATIONSHIP: SELF SPOUSE PARENT OTHER

NAME OF INSURANCE PLAN \_\_\_\_\_

ID \_\_\_\_\_ GROUP # \_\_\_\_\_

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I GIVE THE PHYSICIANS & STAFF PERMISSION TO SPEAK TO THE FOLLOWING PEOPLE ABOUT MY MEDICAL OR INSURANCE ISSUES (PLEASE INCLUDE YOUR RELATIONSHIPS WITH THE FOLLOWING PEOPLE AND THEIR PHONE NUMBERS): \_\_\_\_\_  
\_\_\_\_\_

I AM AWARE THAT BRICK WOMEN'S PHYSICIANS MAY IMPOSE INTEREST CHARGES (8% apr) ON ANY PATIENT BALANCES BEYOND 90 DAYS FROM DATE OF SERVICE.

I AM GRANTING PERMISSION FOR YOU TO VIEW MY PRESCRIPTION HISTORY FROM EXTERNAL SOURCES

I AGREE THAT THE INFORMATION ABOVE IS CORRECT AND AGREE TO THE TERMS ABOVE:

\_\_\_\_\_  
**PATIENT SIGNATURE**

\_\_\_\_\_  
**DATE**