CHICAGO
women's
HEALTH GROUP

New Patient Information

Last Name: _____ First Name: _____ Middle: _____

Nickname/Preferred Name: _____ Date of Birth: _____

What brings you to the office today?_____

Do you have any questions, problems, or concerns that you would like to discuss with us today?

_____

What are your gender pronouns?

- ☐ She, her, hers, herself
- ☐ He, him, his, himself
- ☐ They, them, theirs, themselves
- ☐ Ze, hir, hirs, hirself
- ☐ Just my name, please
- ☐ Other _____

What is your ethnicity/ancestry?

- ☐ Ashkenazi Jewish
- ☐ Asian
- ☐ Black/African American
- ☐ French Canadian
- ☐ Hispanic/Latinx
- ☐ Mediterranean
- ☐ Native American or Alaska Native
- ☐ Pacific Islander or Native Hawaiian
- ☐ Sephardic Jewish
- ☐ White/Caucasian
- ☐ Other _____

Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Please circle the number where we may leave a detailed, confidential message.

Email Address: _____

Preferred Pharmacy Name: _____

Pharmacy Address: _____

City: _____ State: _____ Zip Code: _____

How were you referred to our office?

Patient (name): _____

Facility (full name): _____

Physician (first and last name): _____

Social media (which platform): _____

Employer Information

Name: _____

City: _____ State:_____ Zip Code: _____

Position: _____ Status: Full-Time ☐ Part-Time ☐

Emergency Contact

Name: _____

Relationship: _____

Phone Number: _____

Your insurance is necessary for us to process any insurance claims and to ensure payments of service rendered.

I authorize the release of all medical information necessary to process this claim and that is pertinent to my medical care. I assign all medical and/or surgical benefits, including major medical benefits to which I am entitled, to Chicago Women's Health Group. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original.

Signature (Patient and/or guardian if minor): _____ Date: _____