WOMAN'S CLINIC
for Breast & Gynecological Care

PINK DOOR IMAGING

PATIENT INFORMATION RECORD

Today's Date: _____Time:_____ **Reason for Exam**: _____

Patient Name: **Last, First, MI** _____ **Date of Birth:** _____
SS# _____**Marriage Status: Married / Single** **Female / Male**
Home Phone: _____Work Phone: _____Cell: _____
Street Address: _____City/State_____ Zip code_____
Email Address: _____
Employer: _____
Address: _____

Optional:
Ethnicity: _____Language: _____
Current Smoker_____ Quit Smoking_____ Years_____

ALLERGIES: _____

Date of Last Mammogram: _____ **Facility Name:** _____
(Fill out request to obtain medical records form)

(Order required that matches appointment)
Referring Physician: _____
Office Number: _____ Fax Number: _____
2nd Physician: _____
Office Number: _____ Fax Number: _____

Primary Insurance Carrier: _____
Patient ID # _____ Group # _____
Insurance Address: _____
Policy Holder: _____ Relation to Patient: _____
Policy Holder SS# _____ Policy Holder DOB: _____
Policy Holder Employer: _____

Secondary Insurance Carrier: _____
Patient ID # _____ Group # _____
Insurance Address: _____
Policy Holder: _____ Relation to Patient: _____
Policy Holder SS# _____ Policy Holder DOB: _____
Policy Holder Employer: _____

Emergency Contact Person: _____
Home Phone: _____Work: _____Cell: _____
How did you hear about us: _____