Obstetric & Gynecology
PHYSICIANS OF FLINT, PC

Patient Information Form:

Name: Date of Birth: Age:

Address: Home Phone:

City/State/Zip: Cell Phone:

Email: Social Security #:

Preferred Method of Contact (check one): Home Phone Cell Text to Cell Email

Employer: Occupation:

Work Address: Work Phone:

Primary Care Physician: Primary Care Phone:

Pharmacy:

Spouse Name: Spouse Phone: Spouse DOB:

Where did you hear about us?

Family Physician Another Patient Internet Search Other

Spouse Information

Name: Date of Birth: Social Security #:

Employer: Work Phone:

Insurance Information

Primary Insurance: Contact No.:

Insured Name on Card: Group No.:

Insured Date of Birth: Relationship to Patient:

Secondary Insurance: Contact No.:

Insured Name on Card: Group No.:

Insured Date of Birth: Relationship to Patient:

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Confidential Communications:

I authorize the practice of leaving a message on my answering machine/voicemail ☐ **Yes** ☐ **No**

I authorize the release of my protected health information over the phone to the following individuals:
(Note: The individual(s) listed below will be allowed to receive medical information about you and your care.)

Name: Relationship:

Home Phone: Work Phone:

Name: Relationship:

Home Phone: Work Phone:

Signature: Date: