Hudson Valley Women's Medical Group
Patient Information Sheet

Last Name_____First Name_____MI____
Maiden Name_____
Address_____
City_____State_____Zip_____
Home Phone#_____Work Phone#_____
Cell Phone#_____Email Address_____

Place of Employment/Occupation_____
Date of Birth_____SS#_____Married Y N

Emergency Contact_____Relation_____Phone#_____
Referred by_____

Primary Care Physician_____Phone#_____

Primary Insurance_____Effective Date_____
Insurance ID#_____Group Name_____Group#_____
Policy Holder_____SS#_____DOB_____
Relation to Patient(circle one) Self Spouse Child Other_____

Secondary Insurance_____Effective Date_____
Insurance ID#_____Group Name_____Group#_____
Policy Holder_____SS#_____DOB_____
Relation to Patient(circle one) Self Spouse Child Other_____

I certify that the above information is correct to the best of my knowledge. I the undersigned certify that I have insurance coverage with_____and assign directly to Dr. Carol Harracksingh all insurance benefits. I further understand that I will be responsible for any charges not covered by my insurance carrier. I also understand that a fee of $80.00 will be charged to me for any appointment canceled without 24 hour notice. I also authorize release of any medical information to my Primary Care Physician and/or insurance carrier. I also certify that I have read and have been given a copy of Hudson Valley Women's Medical Group Notice of Privacy Practices describing how my medical information may be used and disclosed and how I can access my medical information.

Signature_____Date_____