235 Plain Street
Providence, RI
Ph: (401) 421-1710
Fax: (401) 861-2164

PLEASE FILL OUT ENTIRE FORM AND BRING WITH YOU TO YOUR APPOINTMENT

FIRST NAME:____LAST NAME:______________________________________
MAIDEN NAME:_______________________________________MARITAL STATUS:__________________SEX:______________
ADDRESS:_____________________________________CITY:________________________STATE:_______ZIP:______________
DATE OF BIRTH:_______________HOME PHONE:______________________PREFERRED CONTACT #___________________
SOC.SEC. NUMBER:_______________________________ PHARMACY PHONE:_______________________________________
EMAIL ADDRESS:____

EMPLOYER:____ WORK PHONE:_________________ EXT:_______
EMPLOYER ADDRESS:_____________________________CITY____________________STATE_____________ZIP:___________
OCCUPATION:____

RACE:____ HISPANIC OR LATINO: Yes ______ No ______
PREFERRED LANGUAGE:____

CONTACT PERSON IN CASE OF EMERGENCY:____
RELATIONSHIP:___________________________________ EMERGENCY CONTACT #:______________________________

PRIMARY CARE PHYSICIAN:____
ADDRESS_________________________________CITY_____________________STATE________PHONE:________________

INSURANCE INFORMATION: Name of Insurance Company (please be as specific as possible)

INSURANCE NAME:____
INSURANCE CO. ADDRESS:____
NAME OF PERSON HOLDING POLICY:_______________________________________RELATIONSHIP:__________________
SOCIAL SECURITY #____DATE OF BIRTH.___________________________
SUBSCRIBER NUMBER:____GROUP NUMBER:_____________________

IF YOU HAVE TWO INSURANCES, PLEASE COMPLETE THE FOLLOWING:

SECONDARY INSURANCE CO. NAME:____
INSURANCE CO. ADDRESS:____
NAME OF PERSON HOLDING POLICY:_____________________________________RELATIONSHIP:___________________
SOCIAL SECURITY #____DATE OF BIRTH.___________________________
SUBSCRIBER NUMBER:____GROUP NUMBER:_____________________

PLEASE READ AND SIGN BELOW:

I hereby request payment of medical benefits either to myself or to the physicians or party who accepts assignment.

I hereby authorize BAYSIDE OB/GYN, INC. and TERRENCE F. CAHILL, M.D. to release records for insurance purposes, any information acquired in the course of my examination and medical treatment.

Signature:____Date:__________________________________