Susan Fox, D.O.
F.A.C.O.O.G.

Natalya Medrano, M.D.
F.A.C.O.G

Dr. SUSANFOX'S
center for women

Office: (305) 595-6488

Susan Fox, DO, FACOOG
Laura Briz, ARNP
Natalya Medrano, MD, FACOG

Fax: (305) 595-3532

PATIENT INFORMATION

Last Name: _____ First Name: _____ D.O.B _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____ Work: _____

SS# _____ Marital Status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Race: ☐ White ☐ Black ☐ Asian ☐ Other Ethnicity: ☐ Not Hispanic ☐ African American ☐ Hispanic ☐ Other

Name of Employer: _____ Occupation: _____

Emergency Contact: _____ Relationship: _____ Phone: _____

Primary Care Physician: _____ Phone: _____

Pharmacy Name: _____ Phone: _____ Fax: _____

Reason for the visit? ☐ Annual ☐ Pregnancy ☐ Gyn Problem ☐ Other Why? _____

Email Address: _____

INSURANCE INFORMATION

Insurance Name: _____ Member ID: _____

Subscriber's Name: _____ D.O.B _____ Relationship: _____

Do you have an Advance Directive? ☐ YES ☐ NO "If YES please provide the SF OB-GYN a copy"

An Advance Medical Directive is the direction you give about the kind of health care you wish to have if you lose ability to make decisions. It is advisable for you to discuss available options with your physician. An Advance Medical Directive can for example be in the form of living will. It is often helpful for you to consult a lawyer in connection with your right to execute such Advance Medical Directive.

CONSENT:

I approve my physician to leave NORMAL test results on my answering service: ☐ YES ☐ NO

If I am not available to receive my test results, I authorize SF OB-GYN to release this information to: _____

_____

I have completed this form and certify that I am the patient or duly authorized agent of this form and authorized to furnish the information requested. I understand that even though I may have some type of insurance coverage. I am responsible for payment and that payment is due on the date of service is received. I understand that if I have a HMO policy, I need to bring a referral to my specialist office in that date of service. I authorize the release of my medical history information or concerning my diagnosis and treatment by SF OB-GYN. I may be required to substantiate or explain insurance claims filed, I authorize payment directly to SF OB-GYN and permit a copy of this authorization to be used in place of the original. This authorization will remain in effect until revoked by me in writing. If I have Medicare coverage, I request that payment of authorized Medicare benefits be made to SF OB-GYN for any services furnished me by that physician or supplier.

Signature of Patient or Authorized Person: _____ Date: _____