Dana Schey M.D.
Diplomate, American Board of Obstetrics & Gynecology

Please fill out this registration form as completely as possible.
Return this form with your insurance card(s) and drivers license to the receptionist.

Date_____ / _____ / _____

E-mail: _____

PATIENT

Patient Name: _____

Local Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Work: _____ Ext:_____

Cell:_____

Marital Status:_____ Sex: M F Date of Birth_____

Social Security #: _____ Driver's Lic. #: _____

Employed By: _____ Position: _____

Address:_____

Family Physician (PCP): _____ Phone:_____

SPOUSE/OTHER *(If applicable)*

Name:_____ Date of Birth: _____

Employer:_____

Address:_____

Work Phone: _____ Cell: _____

INSURANCE

Primary Plan:_____(HMO, PPO, POS, EPO, OTHER_____)

ID #: _____ Group #:_____

Name of Insured: _____ Relationship to Patient:_____

Insured SS #:_____ Insured Date of Birth: _____

Secondary Plan:_____(HMO, PPO, POS, EPO, OTHER_____)

ID #: _____ Group #:_____

Name of Insured: _____ Relationship to Patient:_____

EMERGENCY CONTACT INFORMATION

Name:_____ Relationship to Patient:_____

Home Phone: _____ Work: _____ Ext:_____

Cell:_____ Pager Cell: _____

REASON FOR YOU VISIT TODAY

_____

_____

_____

_____

_____

_____

_____

_____

_____

SOCIAL ISSUES

Tobacco _____ No _____ Yes

packs per day _____

Alcohol _____ No _____ Yes

Amount_____

LIST MEDICATIONS CURRENTLY TAKING

_____

_____

_____

_____

_____

Allergies to medications or food

_____

_____

_____

Do you have advance directives

(Living Will)? _____ No _____ Yes

Primary Language Spoken:

_____

Do you want us to leave a message with results on your answering machine at home? _____

Do you want to leave a message at your place at work to return our call?_____

Do you allow us to discuss your medical condition with any member of your household?_____ If yes, with whom/relationship?_____

Signature of patient or guardian:_____Date:_____