Tamar K. Gottfried, M.D. F.A.C.O.G. P.L.C.

Board Certified

Obstetrics and Gynecology

Date: _____

Last Name _____ First Name _____ MI _____
Address _____ Apt _____ City _____ State _____ Zip _____
Home # _____ Work # _____ Cell # _____
Birth Date _____ Age _____ Social Security # _____
Preferred Language: _____ Email: _____
O.K. to contact you by email? [ ] Yes [ ] No
Do you have an Advanced Directive? [ ] Yes [ ] No Do you have a Living Will or Medical Power of Attorney? [ ] Yes [ ] No

☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widowed ☐ Minor

Race (Check all that apply):

☐ White ☐ Black/African Am ☐ Asian
☐ Native Hawaiian/Pacific Islander ☐ Native American
☐ Other: _____

Ethnicity:

☐ Hispanic/Latino
☐ Non-Hispanic/Non-Latino
☐ Unknown

Phone number where you prefer to be reached _____ O.K. to leave a detailed msg? [ ] Yes [ ] No
Employer(Patient) _____ ☐FT ☐PT
Address _____
Primary Care Physician's Name _____ Phone # _____
Pharmacy Name _____ Phone# _____
How did you hear about our office? _____ Who may we thank? _____

EMERGENCY CONTACT

Name _____ Home # _____ Relationship _____

RESPONSIBLE PARTY

Responsible Party (**If a minor**) _____ Relationship _____
Address _____ Apt _____ City _____ State _____ Zip _____
Home # _____ Work # _____ Cell # _____
Birth Date _____ Age _____ Social Security # _____
Employer Name and Address _____

PRIMARY INSURANCE

Insurance Name _____ Id # _____ Grp # _____
Claims Address _____ City _____ State _____ Zip _____
Phone # _____ Relationship to patient _____
Policy Holder's Name _____ DOB _____ SS# _____
Policy Holder's Employer _____ Address _____
Policy Holder's Work# _____ Cell # _____

SECONDARY INSURANCE INFORMATION

Insurance Name _____ Id # _____ Grp # _____
Claims Address _____ City _____ State _____ Zip _____
Phone # _____ Relationship to patient _____
Policy Holder's Name _____ DOB _____ SS# _____
Policy Holder's Employer _____ Address _____
Policy Holder's Work# _____ Cell # _____