



Clermont Obstetrics, Gynecology & Infertility, PA
1099 Citrus Tower Blvd, Suite 110
Clermont, Florida 34711
Phone (352) 241-6460
Fax (352) 241-6461
www.clermontwomen.com

PATIENT *Registration*

PLEASE PRINT.

Name _____
Address _____
City _____ State _____ Zip _____
Home Phone _____
Employer _____
Work Phone/Ext _____
Cell Phone _____

Referred by: Insurance / Friend / Physician /
Newspaper / Yellow Pages / Internet

Emergency Contact
Name _____
Address _____
City _____ State _____ Zip _____
Home Phone _____
Work Phone _____
Relationship _____

Insurance Information
Insurance Company _____
Person Insured _____
Policy ID # _____
Group # _____
HMO ___ PPO ___ EPO ___ POS _____

Age _____ Birthday ____/____/_____
Social Security Number ____/____/_____
Occupation _____
Student: Yes / No Full Time / Part Time
Email address: _____
Spouse Name: _____
Spouse's date of birth: _____
Marital Status _____
Primary Care Physician _____
Office Phone Number _____

Primary Person Insured
Name _____
Social Security Number ____/____/_____
Employer _____
Occupation _____
Date of Birth ____/____/_____
Phone Number _____

Secondary/Supplemental Insurance
Insurance Company _____
Person Insured _____
Policy ID # _____
Group # _____

I understand that Clermont OB/GYN & Infertility, PA's "Notice of Privacy Practices." is posted in the Waiting room for my review and a copy will be provided to me upon my request.

Signature

Date



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CONFIDENTIALITY *Questionnaire*

1. Please list the family members or other persons, if any, whom we may inform about your general medical condition and your diagnosis (including treatment, payment and health care options).

2. Please list the family members or significant others, if any, whom we may inform about your medical condition ONLY IN AN EMERGENCY.

Name _____ Phone _____

3. Please print the address where you would like your billing statements and/or correspondence from our office to be sent if other than your home.

4. Please indicate if you want all correspondence from our office sent in a sealed envelope marked "CONFIDENTIAL."

YES ____ NO ____

5. Please print the telephone number where you want to receive calls about your appointments, lab, x-ray results or other health care information if other than your home phone number.

6. May we leave a message on your answering machine regarding your results, appointments or other health care information?

YES ____ NO ____

7. Please be aware that a cell phone is not a secure and/or private line.

Print Patient Name

Signature of Patient or Guardian

Date _____

Kristina M. McLean, MD, Mary Beth Lewis, MD
Board Certified Providers