Lake Oswego GYN
Personalized Care for Women

PATIENT DEMOGRAPHICS

Patient's Name: _____ DOB: _____
First *Last* *MI*

Mailing Address: _____

City: _____ State: _____ ZIP: _____

Home Phone: _____ Cell: _____ Work: _____

SS#: _____ Primary Care Physician: _____

Email Address: _____

Preferred Method of Contact (please check one): ☐ Cell ☐ Home ☐ Email

○ It is ok to leave a detailed message on the following number: _____

Preferred Pharmacy: _____ Address: _____

Case of Emergency: _____ Phone: _____

Others Involved in Healthcare

As required by the Privacy Laws, Dr N Gyn may not use or disclose your protected health information without your authorization:

I hereby authorize Dr N Gyn and any of her employees to release or discuss my health status or health care information with: (i.e. spouse, child, and or parent)

_____
Name and Relation

_____
Name and Relation

○ I decline to release any information to anyone at this time.

_____ _____
Patient Signature *Date*