Champlain
OBSTETRICS & GYNECOLOGY
Experienced, comprehensive & compassionate care that puts you first.

PATIENT INFORMATION

Date of Birth________________________ **Today's Date**________________
Full Name____
Last First (Given) Middle Maiden
Mailing Address____
Street Town State Zip
Home Phone________________________ **Work Phone/ext**____________________________
Mobile Phone ______________________ **E-Mail Address** ____________________________
Social Security Number______-_______-________ **Marital Status** S M D W
Employer_______________________________**Occupation**____________________________
Employer Address____
Street Town State Zip
Name of Spouse/Partner (if applicable) ____
Occupation___________________________________ **Work Phone**_____________________
Employer/Address____
Emergency Contact (if other than above)
Name___________________________________ **Relationship**________________________
Address____
Street Town State Zip
Home Phone______________________________ **Work Phone**_________________________
Referring Doctor__________________________ **Primary Doctor**______________________
Allergies to Medication(s)____
How Did You Hear About Us____

INSURANCE INFORMATION

Insurance Name________________________________ **Certificate/ID #**_________________
Group #____________ **Policy Holder**____
Relationship________ **Policy Holder Social Security #** ______-______-_________
Policy Holder Date of Birth:__________________
Policy Holder Address if different than above:

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Street Town State Zip