Michele Thomas, M.D.
Patrice Harold, M.D.

Southfield OBGYN

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Phone 248-354-2201
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DEMOGRAPHIC REVIEW

Name_____
(First) (Last) (Middle Initial)

Address:_____
City/State/Zip: _____
Date of Birth:_____
SSN:_____
Marital Status:
☐Married ☐Single ☐Divorced ☐Widow ☐Separated

Cell Phone ( )_____
Home Phone ( )_____
Work number ( )_____
Email Address:_____
Preferred Contact phone number is:
☐ Home ☐ Mobile ☐Work

Employer Name:_____
Employer Phone( )_____
Employer Fax( )_____

Patient Race:
☐ American Indian or Alaska NA ☐ Asian
☐ Black or African American ☐ White
☐ Native Hawaiian or Pacific Islander ☐ Other Race
☐ Hispanic or Latino _____

Emergency Contact:_____
Emergency Phone( ) _____
Emergency Cell ( )_____
Emergency Contact Relationship: _____

Pharmacy Name:_____
Pharmacy Phone:_____
Pharmacy Fax:_____
Pharmacy Address:_____
City/State/Zip:_____

Primary Language Spoken:
☐ English ☐ Spanish ☐ Other: Specify_____

Primary Insurance Company: _____
Primary Guarantor Name:_____
Primary Guarantor Relationship:_____
Primary Subscriber Date of Birth:_____
Primary Guarantor Employer: _____
Primary Subscriber ID#_____

Secondary Insurance Company: _____
Secondary Guarantor Name: _____
Secondary Guarantor Relationship:_____
Secondary Guarantor Date of Birth:_____
Secondary Guarantor Employer:_____
Secondary Subscriber ID#_____

Primary Care Physician: _____
Address:_____
City/State/Zip:_____
Phone ( )_____
Fax ( )_____

Please Check yes or no:
Do you have a legal written document *which allows a specific person to make medical decisions for you; if you are not able to?* (Advance Directives)

☐Yes or ☐ No

I _____, consent to investigation and treatment upon each visit, including a medication history for medication reconciliation/prescription(s). I hereby authorize Dr. Patrice Harold and Dr. Michele Thomas to bill my insurance carrier for services rendered. In the event that my insurance carrier does not pay, I agree that I am responsible for payment.

Patient Signature_____Date_____

Guardian Signature_____Date_____