Fairhaven Obstetrics & Gynecology, Inc. **www.fairhavenobgyn.org**
1111 Lighthouse Lane, Goshen, IN 46526 **Ph. (574) 533-0348**

Dear Patient:

Welcome to our office! We look forward to participating in your medical care. To assist you in receiving care, we would like to acquaint you with our office policies.

Our office hours are Monday through Friday, 8:00 a.m. – 5:00 p.m. If you have an EMERGENCY situation after office hours, telephone our office at 533-0348 for recorded information about the doctor on call.

Please notify our office at least 24 hours in advance if you are unable to keep your scheduled appointment. Please do not bring young children with you to your initial appointment.

You can read our payment policy that explains our billing and collection policies under the insurance and payment section of our website. Please review it before your visit and keep it for future reference.

We have enclosed our patient demographic form that you should complete and return to our office before your appointment. This will allow us to enter most of your personal and insurance information into our computer and avoid delays the day of your appointment. It would be helpful if you could also send a copy of the front and back of your CURRENT insurance card.

Sincerely,

Fairhaven OB/GYN and Staff

Fairhaven Obstetrics & Gynecology, Inc. **www.fairhavenobgyn.org**
1111 Lighthouse Lane, Goshen, IN. 46526 **Phone: (574) 533-0348** **PLEASE PRINT**

DATE_____YOUR COMPLETE LEGAL NAME_____

SINGLE___MARRIED___WIDOWED___DIVORCED___AGE_____DATE OF BIRTH_____RACE_____

CONTACT PHONE #_____ALTERNATE PHONE #_____

SOCIAL SECURITY #_____ADDRESS_____

CITY_____STATE_____ZIP CODE_____

E-MAIL_____PLACE OF EMPLOYMENT_____

EMPLOYMENT ADDRESS_____EMPLOYMENT PHONE_____

HOW DO YOU PREFER WE CONTACT YOU? (PLEASE CHECK ONE) E-MAIL____WORK____PHONE_____

HUSBAND'S LEGAL NAME_____

HUSBAND'S SOCIAL SECURITY #_____HUSBAND'S DATE OF BIRTH_____

HUSBAND'S PLACE OF EMPLOYMENT_____CITY_____

DO YOU HAVE INSURANCE COVERAGE? YES_____NO_____

IF YOU ARE COVERED UNDER YOUR PARENTS INSURANCE PLEASE PROVIDE THE FOLLOWING:

MOTHER'S NAME_____FATHER'S NAME_____

MOTHER'S EMPLOYMENT_____FATHER'S EMPLOYMENT_____

MOTHER'S SOCIAL SECURITY #_____FATHER'S SOCIAL SECURITY #_____

MOTHER'S DATE OF BIRTH_____FATHER'S DATE OF BIRTH_____

LIST PERSON(S) TO NOTIFY IN CASE OF EMERGENCY:

NAME_____ADDRESS_____

PHONE # DAY_____NIGHT_____RELATIONSHIP TO YOU_____

NAME_____ADDRESS_____

PHONE # DAY_____NIGHT_____RELATIONSHIP TO YOU_____

YOUR FAMILY PHYSICIAN_____

HAVE YOU PREVIOUSLY SEEN OUR DOCTORS IN THE HOSPITAL OR IN THE OFFICE?_____

PLEASE LIST ANY PREVIOUS NAMES YOU HAVE HAD_____

HOW DID YOU HEAR ABOUT FAIRHAVEN?_____

PLEASE PRESENT PHOTO I.D. WITH CURRENT ADDRESS &