AMY GARCIA, MD
GYNECOLOGY

PATIENT INFORMATION

Today's Date: ____/____/_____

Name: _____ Date of Birth: ____/____/_____
First Middle Initial Last

Address: _____

City: _____ State: _____ County: _____ Zip Code: _____ - _____

Mobile Phone: (___) _____ Work Phone: (___) _____ Home Phone: (___) _____

Email Address: _____ Okay to email me statements/bills ☐

My pronouns are: ☐ He/him/his ☐ She/her/hers ☐ They/them/theirs
☐ Another pronoun: _____ ☐ Decline to answer

My relationship status: ☐ Single ☐ Never married ☐ Divorced ☐ Married ☐ Partnered not living together
☐ Domestic partnership/living with a partner ☐ Polyamorous/non-monogamous
☐ Widowed/grieving the loss of a partner ☐ Decline to answer

My sex at birth is: ☐ Male ☐ Female ☐ Non-Binary ☐ Not designated on birth certificate
☐ Decline to answer

My current gender identity: ☐ Male ☐ Female ☐ Transgender Female/Transgender Woman
☐ Transgender Male/Transgender Man ☐ Two-spirit ☐ Genderqueer/Gender Fluid ☐ Intersex
☐ Non-binary/Gender Non-Conforming ☐ Another identity: _____ ☐ Decline to answer

My sexual orientation is: ☐ Heterosexual ☐ Lesbian ☐ Gay ☐ Bisexual ☐ Pansexual ☐ Queer ☐ Asexual
☐ Questioning ☐ Another identity: _____ ☐ Decline to answer

My ethnic heritage is best represented by:(choose all that apply) ☐ Latinx/Hispanic ☐ White/Caucasian
☐ Black, Afro-Caribbean or African American ☐ East Asian ☐ South Asian or Indian
☐ Middle Eastern or Arab ☐ Native American, and if so what tribe(s): _____
☐ Decline to answer ☐ Another identity: _____

Emergency Contact: _____ (_____)_____ _____
Name Phone Number Relationship

Primary Provider: _____ ☐ MD ☐ DO ☐ CNP ☐ PA ☐ Other _____

Referred By: _____ ☐ MD ☐ DO ☐ CNP ☐ PA ☐ Other _____

Preferred Pharmacy: _____ Location: _____ Phone: (___)_____

Primary Insurance Company: _____

Policy Holder: ☐ Self ☐ Other: _____ ___/___/_____ _____
Name Date of Birth Relationship

Policy Number: _____ Group Number: _____

Secondary Insurance Company: _____

Policy Holder: ☐ Self ☐ Other: _____ ___/___/_____ _____
Name Date of Birth Relationship

Policy Number: _____ Group Number: _____