CONNECTICUT COASTAL OB/GYN, P.C.

Community OB/GYN Group partnered with Yale Medicine
https://www.yalemedicine.org/
Fax Form to Yale Medicine: 475-246-9946
Rev.02/2023

PLEASE COMPLETE BOTH SIDES OF THIS FORM

PRIMARY CARE PHYSICIAN: _____
(Name) (City) (State)
REFERRING PHYSICIAN: _____
(Name) (City) (State)

INFORMATION ABOUT THE PATIENT: (Please complete ALL of this section)

Name: _____
(Last) (First) (Middle) (MAIDEN)
Address: _____
(Number and Street) (City) (State) (Zip)
Phone Numbers: Home_____Cell_____Work_____***Preferred Contact Number***_____

Date of Birth _____Social Security #_____ Email (for MyChart use)_____

Marital Status: ◻ Single ◻ Married ◻ Divorced ◻ Widowed ◻Separated ◻ Life Partner

Spouse/Life Partner Name_____

Emergency Contact: _____
(Name) (Relationship to Patient) (Contact Number)
Ethnicity: ◻ Hispanic or Latino or Spanish Origin ◻ Not Hispanic or Latino or Spanish Origin
Race: ◻ American Indian/Alaskan Native ◻ Asian ◻ Black/African American ◻ Native Hawaiian/Other Pacific Islander
◻ White/Caucasian ◻ Other_____
Preferred Language: _____Requires Interpreter_____

Employment Status: ◻ Full Time ◻ Part Time ◻ Retired ◻ Disabled ◻ Active Military ◻ Self Employed ◻ Not Employed
◻ Student Full Time ◻ Student Part Time ◻ Other_____

Patient's Employer: _____Occupation_____

Employer's Address_____

PATIENT REQUEST FOR CONFIDENTIAL COMMUNICATIONS
I GIVE PERMISSION FOR YOU TO CONTACT OR SPEAK TO THE FOLLOWING PERSON OR PERSONS REGARDING ANY AND ALL HEALTH CONDITIONS:

NAME_____***RELATIONSHIP***_____***PH#***_____

NAME_____***RELATIONSHIP***_____***PH#***_____

GUARANTOR: (Person responsible for bill if not patient)

Name: _____Date of Birth_____
(Last) (First) (Middle)
Address: _____

Relationship to Patient: _____Social Security #_____

Guarantor Employer_____Phone Number_____

Guarantor Employer Address_____

Signature_____Date_____

Please Complete Applicable Sections for your Insurance

1--Department of income maintenance (T19), HMO or City Welfare.	2--Medicare
Medicaid ID: _____	Medicare ID#: _____
Is this an HMO: Yes_____ No _____	Please refer to your medical card: Do you have?
If yes Name of Insurance:_____	Hospital Part A: ___ Effective Date: _____
ID: _____ Group # _____	Hospital Part B: ___ Effective Date: _____
City Welfare Name & #:_____	
_____	Is the insurance:
Effective Date: _____	Primary: _____
	Secondary: _____

3—Primary Insurance Information	4—Secondary Insurance Information
Insurance Name: _____	Insurance Name: _____
Plan name/ Contract type: _____	Plan name/ Contract type: _____
Ins. Address from card: _____	Ins. Address from card: _____
City, State, Zip: _____	City, State, Zip: _____
Ins. Phone #: _____	Ins. Phone #: _____
Policy/Member ID#: _____	Policy/Member ID#: _____
Group # (if any): _____	Group # (if any): _____
If Policy holder other than patient:	If Policy holder other than patient:
Subscriber name: _____	Subscriber name: _____
Subscriber Employer: _____	Subscriber Employer: _____
Subscriber SS#: _____	Subscriber SS#: _____
Sub. Date of Birth: _____ Male/Female	Sub. Date of Birth: _____ Male/Female
Sub. Relation to Patient: _____	Sub. Relation to Patient: _____
Effective Date: _____	Effective Date: _____
Does this Insurance cover Hospital Services? Y/N	Does this Insurance cover Hospital Services? Y/N

5—Is this a Workman's Compensation Claim? Y/N

Case number: _____ Date of Injury: _____

Injury Description (Neck injury, etc.): _____

Employer at time of injury(if different from current employer): _____

Employer Address: _____

Phone number: _____

Complete section 3 with Insurance carrier information.

Please provide us with a contact name and phone number in case there is need for additional information regarding your workman's compensation claim.

Contact Name: _____ Phone: _____