

Women's Wellness Center of S. Florida, P.A.
 Tara A. Solomon, M.D., FACOG
 5901 Colonial Dr #303-Margate, FL 33063

Patient Information Sheet

Today's Date: ____/____/____	Chart Number: _____
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Patient Name: Last _____ First _____ MI _____		Gender: Male _____ Female _____	Date of Birth: ____/____/____
Marital Status: Married _____ Single _____ Divorced _____ Widowed _____		Social Security Number: _____	Driver's License Number: _____
Permanent Address: _____ City _____ State _____ Zip _____		Home Phone: (____) _____	Cell Phone: (____) _____
Local Address (If other than Permanent): _____ City _____ State _____ Zip _____		Work Phone: (____) _____	Local Phone: (____) _____ Referred to our office by: _____

Employer: _____	Employment Status: Full-Time _____ Part-Time _____ Unemployed _____ Retired Student Disabled _____
Employer Address: _____ City _____ State _____ Zip _____	Employer Phone: (____) _____

Person to Contact in Case of Emergency: Last _____ First _____ MI _____	Relationship: _____	Emergency Contact Phone: (____) _____
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Primary Insurance		Secondary Insurance	
Primary Insurance Company: _____		Secondary Insurance Company: _____	
Policy Holder Name (if not Medicare): Last _____ First _____ MI _____		Policy Holder Name: Last _____ First _____ MI _____	
Policy Holder Address: _____ City _____ State _____ Zip _____		Policy Holder Address: _____ City _____ State _____ Zip _____	
Relationship to Patient: Self _____ Spouse _____ Parent _____	Social Security Number: _____	Relationship to Patient: Self _____ Spouse _____ Parent _____	Social Security Number: _____
Employer: _____		Employer: _____	
Employer Address: _____ City _____ State _____ Zip _____		Employer Address: _____ City _____ State _____ Zip _____	
Employer Phone: (____) _____	Date of Birth: ____/____/____	Employer Phone: (____) _____	Date of Birth: ____/____/____

Pharmacy Phone Number : _____