Advanced OB/GYN
John P. LaGrand MD
Patricia LaGrand MD

Patient Intake Application (please print)

Patient Name: _____
Last First Middle Initial
Date of Birth:_____Social Security Number:_____
Marital Status (Please circle one) Single Married Divorced Widowed
Prior Name:_____
Street:_____ Apt#_____
City:_____State:_____Zip:_____
Home phone number:_____Mobile:_____
Work phone number:_____
Emergency contact:_____
Relationship of Emergency contact:_____
Phone number of Emergency contact:_____

Employment Information
Patient:
Employed:_____ Not Employed:_____
Occupation:_____
Employer address:_____
City:_____ State:_____Zip Code:_____

Spouse:
Employed:_____ Not Employed:_____
Occupation:_____
Employer address:_____
City:_____ State:_____Zip Code:_____

Preferred Pharmacy_____

We will need to make a copy of your insurance card at the appointment and any time there are changes. The following is needed if your current insurance coverage is through some one other than the patient.
Name of policy holder:_____ Date of birth of policy holder:_____

I authorize payment of medical benefits directly to Dr. John LaGrand
Signature:_____ Date:_____

I authorize the release of medical information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment.
Signature:_____ Date:_____