
Alamo Women's Clinic of Illinois

2800 W Main Street
Carbondale, Illinois 62901

PATIENT INFORMATION

PATIENT NAME: _____

First Name

Middle Initial

Last Name

PREFERRED NAME: _____ PREFERRED PRONOUNS: She/Her; He/Him; They/Them

DATE OF BIRTH: _____ AGE: _____

CITY: _____ STATE: _____ ZIP: _____

COUNTY: _____ RACE: _____

*PHONE: _____

May we leave a message? YES / NO *In the instance we may need to reach you.

MARITAL STATUS: ___ M ___ S ___ D ___ W SPOUSE'S NAME: _____

EMERGENCY CONTACT PERSON: _____

EMERGENCY CONTACT PHONE: _____ RELATIONSHIP: _____

FOR STATISTICAL PURPOSES ONLY:

RACE/ETHNICITY: _____ HIGHEST LEVEL OF EDUCATION COMPLETED: _____

PAYMENT ARRANGEMENT: (READ CAREFULLY)

Payment is expected in full amount before services are rendered. ONLY CASH, VISA, MASTERCARD AND DISCOVER, AMEX CARDS AND APPLE PAY ACCEPTED. ALL FUNDING WILL BE APPLIED TO BALANCE.

AUTHORIZATION TO OBTAIN OR RELEASE INFORMATION:

I fully comprehend the privacy notice given to me by Alamo Women's Clinic of Illinois I understand I must complete a medical release form in order to receive copies of my medical records or in order to have any of my medical information released to any person or facility. There is a fee for the release of medical records. I authorize Alamo Women's Clinic of Illinois to contact and give information about my medical condition in the event of an emergency and/or to the emergency contact person listed above.

WE RESERVE THE RIGHT TO REFUSE SERVICES:

To any person requesting an abortion is unaccompanied by a driver on the day of the abortion procedure or on any day on which sedation is administered, is under the influence of alcohol, illegal drugs and / or prescription medication(s) which in any manner may alter the patient's ability to make an informed consent, or any abusive behavior.

The nursing staff has reviewed with me, in the event I need to seek medical attention after I have left the facility; I will contact the on-call nurse and proceed to the hospital closest to my residence.

Hospital: _____ Phone: _____

Patient Signature: _____ Date: _____