WOMEN'S INTEGRATED HEALTHCARE, P.C.

Keith Heslinger, M.D.   Martin Lapa, D.O.   Stacey McEwen, D.O.   Thomas Wright, D.O.

PATIENT INFORMATION

Today's Date__________________

First Name______________________MI________Last Name________________________________ DOB______________

SS#________________________ Age_______ Marital Status: M____ S____ W____ D____ Other___ Gender: F____ M____

Language____________________ Race: White______ Black______ Other_______________ Ethnicity: _________________

Address____City____________________ State______ Zip____________

Home Phone_______________________ Cell Phone________________________ Work Phone____________________

Preferred method of contact: Home, Cell, Work: 1st Choice______________________2nd Choice______________________

E-mail ________________________________ Do you consent to receive automated appointment reminders? Yes___ No___

Primary Care Physician_______________________________________ Physician'sPhone_________________________

How did you hear about us? ______________________________Your Employer_________________________________

Spouse's Name____Spouse's Phone________________________________

INSURANCE

(Please present your insurance cards to front desk so that we can make a copy of it to keep in your record.)

PRIMARY INSURANCE___________________________

Subscriber Name________________________________

SS#____

DOB____

Relationship____________________________________

Employer_______________________________________

SECONDARY INSURANCE________________________

Subscriber Name________________________________

SS#____

DOB____

Relationship____________________________________

Employer_______________________________________

I authorize Women's Integrated Healthcare, P.C. to release any information or diagnosis of my condition to my insurance company. I also authorize and request payment be made directly to Women's Integrated Healthcare, P.C. and I understand that I am financially responsible for any balance due which is not a benefit by my insurance carrier or for any fees charged to me due to my failure to obtain referrals.

____ Relationship________________ Date______________

Signature of responsible person (parent or guardian if patient is a minor)

ALTERNATE CONTACT

First Contact____ Relationship______________________

Phone____ Cell or Work Phone__________________________________

Second Contact____ Relationship______________________

Phone____ Cell or Work Phone__________________________________

Per HIPAA guidelines, to whom may we talk to about/release your medical information? _________________________________

Do you have Advanced Directive? Yes____ No____ Do you have an authorized Power of Attorney? Yes____ No____

YEARLY INFORMATION VERIFIED: Initials_____Date_________ Initials_____Date_________ Initials____Date_________