

WOMEN'S INTEGRATED HEALTH CARE, P.C.

www.womensintegratedhealth.com

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PATIENT INFORMATION

Today's Date: _____

Last Name: _____ M.I. _____ First Name: _____ DOB: _____

SS#: _____ Age: _____ Marital Status: S ___ M ___ W ___ D ___ Other ___ Gender: F ___ M ___

Language: _____ Race: White ___ Black ___ Other _____ Ethnicity: _____

Address: _____ City: _____ State: _____ Zip Code: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

E-Mail: _____ Pref.Method of Contact: 1st Choice _____ 2nd Choice: _____

Do you consent to receive automated/appointment reminders? Y ___ N ___ Doctor seeing today? _____

Primary Care Physician: _____ Primary Care Physician Telephone: _____

How did you hear about us? _____ Employer: _____

Spouses Name: _____ Spouses Telephone Number: _____

Spouses Cell Phone number: _____ Spouses employer: _____

INSURANCE

(Please present card to the front desk so that we may make a copy of it to keep in your record. Please let us know if you have a secondary insurance)

*Primary: _____ Subscriber name: _____

Relationship: _____ Subscriber's SS#: _____

Subscriber's DOB: _____

*Secondary Insurance: _____ Subscriber Name: _____

***I authorize Women's Integrated Health Care to release any information or diagnosis of my condition to my insurance company for the purpose of payment for services rendered to me. I also authorize and request payment be made directly to Women's Integrated Health Care and understand that I am financially responsible for any balance due that is not a benefit by my insurance carrier or for any fees charged to me due to my failure to obtain referrals.**

Signature of Responsible Party

Relationship

Date

EMERGENCY CONTACT

Emergency Contact: _____ Relationship: _____

Phone number: _____ Cell or work Phone: _____

Second Contact: _____ Relationship: _____

Phone Number: _____ Cell or work phone: _____

Per HIPAA Guidelines, to whom may we release your medical history? _____

Do you have Advanced Directive? Y ___ N ___ Do you have an authorized Power of Attorney? Yes ___ No: _____

INFORMATION VERIFIED: Initials ___ Date ___ Initials ___ Date ___ Initials ___ Date ___