PHYSICIANS TO Women INC.

Donna L. Musgrave, M.D.
Lynn M. Keene, M.D.
Dianna L. Curtis, M.D.
Eric D. Swisher, M.D.
Jill A. Gaines, M.D.
Mark W. Chewning, M.D.
Jamie J. Buck, M.D.
Margaret Grove, M.D.
Heather Draeger, M.D.
Brittany C Kane, D.O.
Stephanie Quinn-Phlipot, RNC, WHNP

21 Highland Avenue, Suite 200 • Roanoke, VA 24013 Telephone (540) 982.8881 • Facsimile (540) 982.0612

PATIENT INFORMATION FORM

Today's Date _____

Patient's Name _____
Last First Middle

Mailing Address _____ Email Address _____

Street Address _____
Street/Rt. # Apt. # City/State Zip

Please circle the number you wish to be your primary contact number:

Home Phone _____ Cell Phone _____ Work Phone _____

Birthdate ____/____/____ Age _____ Marital Status _____

Race _____ Ethnicity (Family Background) _____ Primary Language _____

Social Security Number _____ Male _____ Female _____ Other _____

Patient's Employer _____ Time Employed _____

Parent or Guardian's Name (if minor) _____

Address (if different from patient's) _____

Employer of parent _____

Spouse's Name _____ Employer _____ Birthdate ____/____/____

Spouse's work phone _____ Cell _____ Spouse's Social Security Number _____

Emergency, contact / Relationship _____ Phone _____ Birthdate ____/____/____

Have you been seen by any of our physicians before? _____ Who? _____

Family Physician _____ Referred by _____

Person responsible for payment _____ Relationship _____

A copy of the Notice of Health Information Practices is posted for your review. Please sign below.
Date _____ Signed _____

I hereby authorize Physicians to Women, Inc. to release information to my insurance company. I hereby assign and direct payment to Physicians to Women, Inc. of the benefits herein specified and otherwise payable to me but not to exceed the doctor's regular charges for this treatment or surgical procedures. I understand I am financially responsible to the corporation for charges/charged amounts not covered by this agreement.
Date _____ Signed _____

Virginia State law provides that when a healthcare worker is exposed to the body fluids of another person in a manner which may transmit human immunodeficiency virus (HIV – the virus that causes AIDS), such as an accidental needle stick, the patient shall be deemed to have consented to testing for HIV and to the release of the results to the exposed person and the local health department.
Date _____ Signed _____

By becoming a patient of Physicians to Women, Inc. and presenting myself for appointments with the physicians or nurse practitioners of Physicians to Women, Inc., I consent to and authorize treatment by the qualified care providers of Physicians to Women, Inc. Qualified care providers include, but are not limited to physicians, nurse practitioners, phlebotomists, etc. I hereby agree that the care providers may examine me, perform non-invasive diagnostic tests and treatment to be performed, and that I will sign a separate authorization for any invasive diagnostic tests or medical procedure to be performed.
Date _____ Signed _____

Please have your Driver's License & ALL insurance cards ready for the check in. I understand that if I DO NOT have my insurance information, that I am financially responsible for full payment on the day of my visit.
Date _____ Signed _____

Continued on next page

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PATIENT INFORMATION FORM (continued)

Please Complete and Give Copy of Insurance Card or Cards to Check In.

Primary Insurance Company Information

Primary Insurance Co._____ Primary Policyholder's Name_____

Primary Holders Birthdate_____ Primary Holders SSN_____

Primary Holders Full Address _____

Phone number_____ Primary Holders Place of Employment _____

Primary Ins. Co. Address _____

Phone Number_____ ID#_____ Group# _____

Secondary Insurance Company Information

Secondary Insurance Co._____ Secondary Policyholder's Name _____

Secondary Holders Birthdate_____ Secondary Holders SSN _____

Secondary Holders Full Address _____

Phone number_____ Secondary Holders Place of Employment _____

Secondary Ins. Co. Address _____

Phone Number_____ ID#_____ Group# _____

Tertiary Insurance Company Information (Third)

Tertiary Insurance Co._____ Tertiary Policyholder's Name _____

Tertiary Holders Birthdate_____ Tertiary Holders SSN _____

Tertiary Holders Full Address _____

Phone number_____ Tertiary Holders Place of Employment _____

Tertiary Ins. Co. Address _____

Phone Number_____ ID#_____ Group# _____