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 M. Arliss, M.D.
Jill A. Gaines, M.D.
Mark W Chewning, M.D.
Jamie J. Buck, M.D.
Margaret Grove, M.D.
Elizabeth Barwick D.O.
Brittany Kane D.O.
Stephanie Quinn-Philpot, RNC, WHNP

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

PATIENT INFORMATION FORM

Today's Date ____/____/____

Patient's Name _____

Mailing Address _____

Street Address _____

City/State/Zip _____

PHONE NUMBERS

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

Home Phone (____) _____-_____ Cell Phone (____) _____-_____

Work Phone (____) _____-_____

Birthdate ____/____/____ Age _____

Marital Status Single Race Alaska Native Ethnicity Hispanic Primary Language _____

Social Security Number _____-_____-_____ Gender: F ◉ M ○ Other ○

Patient's Employer _____ Time Employed _____

SPOUSE'S INFORMATION

Spouse's Name _____

Spouse's Birthdate ____/____/____ Spouse's Social Security _____-_____-_____

Spouse's cell (____) _____-_____ Spouse's Work Phone (____) _____-_____

Spouse's Employer _____

EMERGENCY CONTACT

Emergency Contact/Relationship _____

Birthdate ____/____/____

Home Phone (____) _____-_____ Cell Phone (____) _____-_____

Work Phone (____) _____-_____

Person responsible for payment/Relationship _____

Parent or Guardian's Name (if minor) _____

Address (if different from patients) _____

Parent's Employer _____

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

If yes, who? _____

Family Physician _____ Referred by _____

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# _____

Continued on next page

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PATIENT INFORMATION FORM (continued)

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 remember to bring your Driver's License and ALL insurance cards with you on the day of your office visit. I understand that if I DO NOT bring my insurance information, that I am financially responsible for full payment on the day of my visit.

Date _____/_____/_____ Signed _____