FLORIDA WOMAN CARE OF INDIAN RIVER COUNTY, LLC

JAMES J. PRESLEY, M.D. MARIAN A. SAMPSON, M.D. PATRICIA WHITE, A.R.N.P.

PATIENT INFORMATION SHEET

PLEASE **PRINT** CLEARLY

PATIENT'S NAME ________________________ MARITAL STATUS (S M D W)

DATE OF BIRTH ____________________ SOCIAL SECURITY # ______________

MAIDEN NAME ____________________ CELL PHONE ______________

ADDRESS __________________________ HOME PHONE ______________

CITY ____________________ STATE ______ ZIP __________

EMPLOYER __________________________ WORK PHONE ______________

SPOUSE ____________________ DATE OF BIRTH ______________

EMPLOYER __________________________ WORK PHONE ______________

EMERGENCY CONTACT ____________________ PHONE ______________

REFERRED BY ____________________ FAMILY DOCTOR ______________

PREFERRED PHARMACY ______________ PHONE______________

PHARMACY LOCATION __________________________

PRIMARY LANGUAGE __________ RACE ________ETHNICITY: HISPANIC ______

NON-HISPANIC______

**** Florida Woman Care of Indian River County has my permission to leave appointment reminders and clinical information at the following telephone number :(____) __________*

Yes ______ No ______ Please initial __________ Date __________

****Secure email address for Patient Portal coming in late 2014: ______________*

Email address listed is my personal secure email Yes No (Please circle)

Email address listed is a family or multiple user email Yes No (Please circle)

FINANCIALLY RESPONSIBLE PARTY

NAME ________________________ BIRTH DATE ______________

PARENTS OR GUARDIANS (IF PATIENT IS A CHILD)

NAME ________________________ BIRTH DATE ______________

ADDRESS ________________________ PHONE ______________

CITY ____________________ STATE ________ ZIP ______________

THIS FORM MUST BE FILLED OUT FRONT AND BACK