2695 Ulmerton Rd.
Clearwater, FL 33762
Phone: (727) 540-0414
Fax: (727) 540-0672

@ Visionary Centre for Women

Today's Date: _____

JENNIFER S. HAYES DO, FACOOG
SHARON WELSH, MSN, ARNP

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

Home Address: _____
Street Apt# City State Zip

Birth Date: _____/_____/_____ Age: _____ SS # _____-_____-_____ Drivers License # _____

Home # (_____)_____ Cell # (_____)_____ Work # (_____)_____

E-mail: _____

☐ *Check here if you would like to be included in our Visionary Centre for Women quarterly health updates.*

Preferred Contact (CIRCLE): Home Work Cell E-mail

Emergency Contact:_____ Phone # (_____) _____

Primary Care Physician: _____ Phone # (_____) _____

Employer: _____ Occupation: _____

Employer Address:_____ Phone # (_____) _____

Marital Status: ☐ Single ☐ Married ☐ Partnered ☐ Separated ☐ Divorced ☐ Widowed

Spouse Name: _____ Phone # (_____) _____

Date of Birth: _____/_____/_____ SS # _____-_____-_____

Employer: _____ Occupation: _____

RELEASE OF INFORMATION: *We will only discuss your protected health information (PHI) with you unless you authorize us to discuss it with someone else. Please list below the name(s) of individuals you authorize our office to discuss your care with. If this list changes, please notify us in writing.*

_____ _____

_____ _____

I acknowledge that I have been offered a copy of our Notice of Privacy Practices and I have read and understand the above and agree to comply. *(There is a copy of our Notice of Privacy Practices located in our reception area.)*

Patient's Signature: _____ Date: _____/_____/_____