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

Visionary
Centre for Women

JENNIFER S. HAYES DO, FACOOG

Today's Date: _____

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

Home Address: _____
Street Apt# City State Zip

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

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

E-mail: _____

Occupation: _____ Employer: _____

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

Spouse Name: _____ Phone # (_____) _____

Emergency Contact:_____ Phone # (_____) _____

How Would Most Like Us Contact You?: ☐ Cell ☐ Text ☐ E-mail ☐ Home Phone ☐ Work

Primary Care Physician: _____ Phone # (_____) _____

Pharmacy Name: _____ Phone # (_____) _____

Imaging Name: _____ Phone # (_____) _____

Lab Name: _____ Phone # (_____) _____

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.*

_____ _____

_____ _____

☐ ***Check if you would like to receive our quarterly health updates.***

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: _____/_____/_____