

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



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

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: _____

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

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

Emergency Contact: _____ Phone # (____) _____

Employer: _____ Occupation: _____

Primary Care Physician: _____ Phone # (____) _____

Pharmacy Name: _____ Phone # (____) _____

Lab Name: _____ Phone # (____) _____

Imaging Name: _____ Phone # (____) _____

Marital Status: Single Married Partnered Separated Divorced Widowed

Spouse 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.*

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: ____/____/____