Metro Partners in Women's Health
26850 Providence Parkway, Suite 500
Novi, MI 48374
248-662-4388
248-662-3025 (fax)

Date__________________________

Patient Name____ Social Security #___________________________

Address____City_________________________Zip___________

Pt: Home #________________________ Office #_______________________ Cell #________________________

Date of Birth___________________ Marital Status: S M D W

Race: __________ Ethnicity: __________ Language: __________

Employer_______________________________ Occupation_______________________________

Primary Care Physician Name_______________________________________

Email address:____

I have provided MPIWH with a copy of my Advance Directive: Yes No
If No, I have been offered information regarding Advance Directives: Yes No

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Pharmacy Name: _________________ **Pharmacy #**: ____________________

Pharmacy Address: ____

Emergency Contact_______________________________ Relationship_______________________________

Home #________________________ Office #________________________ Cell #________________________

Insurance Information

Insurance____________________________________ Employer______________________________________

Subscriber Name____ Subscriber Date of Birth________________

Subscriber Address_____________________________ City________________________ Zip______________

Messages regarding my results/treatment may be left on my cell or home phone. □ Yes □ No
Messages regarding my results/treatment may be left on my work voice mail. □ Yes □ No
Messages regarding my results/treatment may be left with my spouse/parent. □ Yes □ No

I hereby authorize and provide consent to Metro Partners in Women's Health Providers to furnish the requested diagnostic services and/or treatment and bill for services rendered.

I authorize payment of medical benefits to Metro Partners in Women's Health for services provided. I understand that if my insurance company does not reimburse services, I will be responsible.

Patient or Authorized person's signature: ____

Date: ____________________

******Authorization valid for 1 year from date of signature******