The Whole Woman, PLLC

Amy M. Bruton, MD
Patient Information Sheet

Name_____
First Middle Last preferred

Phone Home_____ Cell_____ Work_____
*please indicate preferred number

Email address_____

Address_____ City_____ State_____ Zip_____

Month/Day/Year of birth____/ ____/ ____ Profession_____

Employment Status: Full-Time/Part-Time/Unemployed/Student Employer_____

Marital Status: Single/Married/Divorced/Widowed/Separated Spouse/Partner_____

Parent/Gaurdian (for minors/disabled)_____ Phone_____

Emergency Contact_____ Phone_____

Contacts relationship to patient_____

Primary Care_____ Referring Physician_____

How did you learn about us? _____

Pharmacy Preference

Pharmacy Name_____ Phone_____

Compounding Pharmacy_____ Phone_____

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Insurance (in case needed for prior authorization or for other testing covered by plan)

Primary Insurance

Name of insurance _____ Employer_____

Name of insured_____ Insured's date of birth _____/_____/_____

Relationship to patient Self/Spouse/Parent

Secondary Insurance

Name of company_____ Employer_____

Name of insured_____ Insured's date of birth _____/_____/_____

Relationship to patient Self/Spouse/Parent

Patient Consent

The Whole Woman, PLLC (hence forth TWW) will only use your health care information for the following reasons:

Treatment: TWW will use your health care information to make decisions about the provision, coordination or management of your healthcare, including but not limited to, analyzing or diagnosing your condition and determining the appropriate treatment for that condition. It may also be necessary to share your health information with another health care provider whom we need to consult with respect to your care. By signing this you acknowledge that you understand that treatment for any and or all of your conditions will be based upon the information which you provide. You are accepting full responsibility should you provide inaccurate, incomplete, or misleading information. You hereby certify that the identifying information, address, and telephone information provided are correct and agree to inform TWW and it's staff if and when such information changes or becomes outdated. You agree that TWW and staff cannot contact you if you have provided incorrect or illegible information or fail to keep your information up to date and correct. You agree to hold harmless TWW for any lack of communication due to any of the above.

Payment: TWW may need to use or disclose information in our health care record to obtain reimbursement from you. We may also need to disclose information to obtain precertification, preauthorization of services, or reimbursement of non-TWW services. This information may also be used for collection purposes and related healthcare data processing through our system.

Operations: Your health care records may be used in our business planning and development operation, including but not limited to, improvements in our methods of operation and general administrative functions. We may also use the information in our overall compliance planning, healthcare review activities, and arranging for legal and auditing functions.

I do hereby agree to allow my health care information to be used for the purpose of treatment, payment, and operations as outlined above.

_____ _____/_____/_____

Patient Signature Date