



TOTALCARE FOR WOMEN
A Division of Mid-Atlantic Women's Care, PLC

Steven B. Powers, M.D., F.A.C.O.G.

George Rector, Jr., M.D., F.A.C.O.G.

Paul I. Lindner, M.D., F.A.C.O.G.

Rhonda J. Bertholf, WHNP, CNM, MSN

NAME: _____ **Preferred Name:** _____
Last First Middle Initial

DOB: _____ **S.S.N:** _____ **EMAIL ADDRESS:** _____

ADDRESS: _____ **UNIT./APT #:** _____

CITY: _____ **STATE:** _____ **ZIP:** _____

HOME PHONE: _____ **WORK PHONE:** _____ **CELL:** _____

(OPTIONAL) LANGUAGE: _____ **RACE:** _____ **ETHNICITY:** _____

MARITAL STATUS: M ___ S ___ W ___ D ___

EMPLOYER: _____ **OCCUPATION:** _____

ADDRESS: _____
Street City State ZIP

EMERGENCY NOTIFICATION:

NAME: _____ **RELATIONSHIP:** _____
Last First

HOME PHONE: _____ **WORK PHONE:** _____ **CELL:** _____

PRIMARY INSURANCE: _____ **POLICYHOLDER'S NAME:** _____

RELATIONSHIP: _____ **DOB** _____ **SSN:** _____

POLICY NUMBER: _____ **GROUP NUMBER:** _____

SECONDARY INSURANCE: : _____ **POLICYHOLDER'S NAME:** _____

RELATIONSHIP: _____ **DOB** _____ **SSN:** _____

POLICY NUMBER: _____ **GROUP NUMBER:** _____

OTHER INSURANCE: : _____ **POLICYHOLDER'S NAME:** _____

RELATIONSHIP: _____ **DOB** _____ **SSN:** _____

POLICY NUMBER: _____ **GROUP NUMBER:** _____

FAMILY PHYSICIAN (The doctor you see regularly)

FAMILY PHYSICIAN: _____ **OFFICE PHONE:** _____

ADDRESS: _____
Street City State Zip

REFERRING PHYSICIAN or FACILITY

REFERRING PHYSICIAN: _____ **OFFICE PHONE:** _____

ADDRESS: _____
Street City State Zip

SIGN

DATE