



Lisa Weiler, M.D. • Michael Stowell, M.D. • Anita Leis, M.D. • Melissa Watters, M.D.
Elizabeth McDaniel, CNM • Jyll Hopkins, WHNP

PATIENT INFORMATION

Today's Date _____ Referral Source _____

Primary Care Provider _____

Your Name _____ Prefer to Be Called _____

Maiden Name _____ S.S.N. ____ - ____ - ____ Date of Birth ____/____/____ Age ____

Home Phone No. _____ Work Phone No. _____

Email address _____ Cell Phone No. _____

Local Address _____

City, State, & Zip _____

Employer _____ Occupation _____

Employer Address _____

City, State, & Zip _____

Emergency Contact _____

Contact Phone # _____ Contact Work Phone # _____

Contact Address _____

City, State, & Zip _____

Status: Single Married Separated Divorced Widowed

Spouse's Name _____

Spouse's Date of Birth ____/____/____ Spouse's S.S.N. ____ - ____ - ____

Employer _____

City, State, & Zip _____ Employer Phone # _____

Employer Address _____

Education: ____years High School ____years College ____years Post-Graduate

Do you prefer an attendant to be present during your examination? Yes No

www.sipw.com

obstetrics • gynecology • infertility • urogynecology • full-scope midwifery

1010 West Second Street • Bloomington, IN 47403 • phone 812.334.3955 817.917.3627 • fax 812.334.5792 • e-mail office@sipw.com



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ADDITIONAL STUDENT INFORMATION

Permanent Address _____

City, State, & Zip _____

Father's Name _____

Father's Address _____

City, State, & Zip _____

Father's Employers Address _____

City, State, & Zip _____

Father's Home Phone # _____ Father's Work Phone # _____

Mother's Name _____

Mother's Address _____

City, State, & Zip _____

Employer Address _____

City, State, & Zip _____

Mother's Home Phone # _____ Mother's Work Phone # _____

INSURANCE INFORMATION

Please present your insurance card so we can make a photocopy.

Policyholders Name _____ S.S.N. _____ - _____ - _____

Patient Relationship to Insured: Self Spouse Child Other _____

Policyholder Information, if other than Self: Date of Birth ____/____/____

Home Phone # _____ Address _____

City, State, & Zip _____

Employer _____ Employer Work Phone # _____

Address _____

City, State, & Zip _____

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LABORATORY AUTHORIZATION

I acknowledge that Southern Indiana Physicians for Women, P.C. uses an external laboratory to interpret all pathology. I understand that my insurance carrier may not cover the services of this laboratory. Therefore, these charges may be my responsibility.

INSURANCE RELEASE

I hereby authorize Southern Indiana Physicians for Women, P.C. to furnish information concerning my illness and treatment to appropriate insurance carriers requesting such information to complete policy requirements.

AUTHORIZATION TO PAY BENEFITS TO PROVIDER

Southern Indiana Physicians for Women, P.C. is hereby authorized to receive payment for the amount due me in my pending claim for provider's services rendered.

BALANCE DUE

I understand that I am financially responsible to Southern Indiana Physicians for Women, P.C. for services rendered, as stated on our "Financial Policy" form.

Signature _____ Date _____

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