

Bernadine Geary, C.R.N.P.
Heather Herman, M.D.
Kenneth Keys, M.D.
Alok Kumar, M.D.
Nicole Luecke, M.D.

 Chesapeake Women's Care, P.A.
Obstetrics & Gynecology

Marcus Penn, M.D.
Lawrence Pritchep, M.D.
M. Kathryn Seuss, C.R.N.P.
Barbara Wells, M.D.

Name: _____ Date: _____

Patient Date of Birth: _____ SS# _____

Allergies: _____ No Allergies: _____

Current Medications: _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Home Ph: _____ Work Ph: _____ Cell Ph: _____

Insurance Company _____

Policy Holder's Name: _____

Policy Holder's DOB: _____ SS# _____

Name of Primary Care Physician: _____

Reason for today's visit:

Routine GYN exam and pap smear: _____ Prenatal care: _____

Consult: _____ Referring Doctor: _____

Other: _____

Signature: _____

NOTE: THE REASON LISTED ABOVE FOR TODAY'S VISIT WILL HELP US BILL YOUR INSURANCE COMPANY PROPERLY AND ACCURATELY. BECAUSE IT IS CONSIDERED FRAUD, WE WILL NOT CHANGE YOUR DIAGNOSIS IF YOUR INSURANCE DOES NOT COVER ANY OF THE SERVICES RENDERED TODAY. IF YOU HAVE QUESTIONS ABOUT YOUR LAB BILL, PLEASE DO NOT CALL THIS OFFICE- CALL THE LAB.

RECEIPT OF NOTICE OF PRIVACY PRACTICES Written Acknowledgment

I, _____ have received a copy of Chesapeake Women's Care's Notice of Privacy Practices.

Signature of Patient: _____ Date: _____