Women's Medicine Collaborative
A program of The Miriam Hospital
A Lifespan Partner

146 West River Street
Providence, RI 02904
(401) 793-5700
WomensMedicine.org

Dear _____ ,

Welcome to the **Women's Medicine Collaborative.**

Your appointment is on _____ at _____ am/pm

with _____ of _____

on the _____ floor.

Please bring the completed new patient packet (enclosed), along with your insurance cards, photo ID, and current medication list.

Please do not mail your packet back to us.

Please arrive 15 minutes prior to your appointment time for registration. If you need to cancel or reschedule your appointment, we request that you do so at least 24 hours in advance. Please call us at (401) 793-5700 if you have any questions.

Driving directions are enclosed. Park in the South parking lot. Parking is free.

For more information about the Women's Medicine Collaborative, please visit our website at *www.WomensMedicine.org.*

We look forward to seeing you.

Sincerely,
Women's Medicine Collaborative

"Helping women reach their greatest health potential in body, mind, and spirit."

Women's Medicine Collaborative
A program of The Miriam Hospital
A Lifespan Partner

2nd Floor - Lifestyle Medicine Center, Bone Density Testing, Massage Therapy, Nutrition, Physical Therapy, Pulmonary Function Testing, Yoga

3rd Floor - Behavioral Medicine, Cancer Survivorship, Cardiology, Diabetes in Pregnancy, Gastrointestinal Medicine, Genetics, GYN Oncology, Obstetric Medicine, Primary Care , Pulmonary Medicine, Rheumatology

Directions

From EAST of PROVIDENCE

- From Route 195, merge onto Route 95 North toward Providence
- Follow Route 95 North to Providence
- Take the Branch Avenue exit (Exit 24)
- Turn left onto Branch Avenue
- Follow Branch Avenue to the first traffic light
- At the traffic light, turn left onto West River Street
- 146 West River Street is on the right (brick mill building)

Park in the South parking lot.

If you accidentally get on Route 146 North (instead of following Route 95 North) and take the Branch Avenue exit off of Route 146 North, you must turn right off of the exit.

From WEST of PROVIDENCE

- Follow Route 146 South to Providence
- Take the Admiral Street exit
- Turn left onto Admiral Street
- Turn right onto Charles Street / RI-246
- Turn left onto West River Street
- 146 West River Street is on the left (brick mill building)

Park in the South parking lot.

From NORTH of PROVIDENCE

- Follow Route 95 South toward Providence (crossing into Rhode Island)
- Take the Branch Avenue exit (Exit 24)
- Turn right onto Branch Avenue
- Follow Branch Avenue to the first traffic light
- At the traffic light, turn left onto West River Street
- Turn right to stay on West River Street
- 146 West River Street is on the right (brick mill building)

Park in the South parking lot.

From SOUTH of PROVIDENCE

- Follow Route 95 North to Providence
- Take the Branch Avenue exit (Exit 24)
- Turn left onto Branch Avenue
- Follow Branch Avenue to the first traffic light
- At the traffic light, turn left onto West River Street
- 146 West River Street is on the right (brick mill building)

Park in the South parking lot.

If you accidentally get on Route 146 North (instead of following Route 95 North) and take the Branch Avenue exit off of Route 146 North, you must turn right off of the exit.

BUS ROUTES

Best service to take is **Route# 51, 52 or 72** to Charles Street and West River Street. Route 51 runs every half hour. Route 52 and 72 both run every 45 minutes or so. Get off at bus stop in front of the Providence Post Office (across the street from the "Subway" sandwich shop). Walk to the corner of Charles Street and West River Street, take a right onto West River Street and walk straight down to our building. It is a brick mill building on the left. Enter into the South parking lot entrance. Contact RIPTA at (401) 781-9400 or online at www.ripta.com for schedules and additional information.

10/27/14

Women's Medicine Collaborative
A program of The Miriam Hospital
A Lifespan Partner
146 West River Street, Providence, RI 02904

Patient Label

REGISTRATION FORM

PATIENT INFORMATION (PLEASE PRINT)

Last Name	First Name	Middle

Birth Date	Social Security #	Email

Street Address	Home Phone ( )

City	State	Zip Code	Alternate Phone ( )

Marital Status (circle one)
Single / Married / Divorced / Separated / Widowed / Life Partner / Civil Union

Preferred Language
Spoken: _____ Written: _____
Interpreter Required? ❑ YES ❑ NO

Sex: ❑ Female ❑ Male Religion: _____

Race (circle one): American Indian / Alaskan Native / American Indian & Native Hawaiian / Asian / Asian & America Indian / Asian & Native Hawaiian / Black & Asian / Black & American Indian / Black & Native Hawaiian / Black-African American / White / White & American Indian / White & Asian / White & Black / White & Native Hawaiian / Other **Hispanic/Latino (circle one):** Hispanic / Non-Hispanic

Are you Employed? ❑ YES ❑ NO	Employer	Occupation	Employer Phone ( )

How did you hear about us?

Provider you are here to see today?

Primary Care Provider (PCP)/Practice Name

PCP Address	PCP Phone ( )

INSURANCE INFORMATION

Please give your insurance card to the receptionist

Person responsible for bill	Birth Date / /	Address (if different)	Home Phone ( )

Is this patient covered by insurance? ❑ Yes ❑ No	Primary Insurance Plan Name

Group #	Policy #	Co-Pay Amount

Subscriber's Name	Subscriber's Birth Date / /	Patient's relationship to subscriber ❑ Self ❑ Spouse ❑ Child ❑ Other _____

Subscriber's Employment Status ❑ Full Time ❑ Part Time ❑ Unemployed	Subscriber's Employer

Name of secondary insurance (if applicable)	Subscriber's Name	Group #	Policy #

Patient's relationship to subscriber ❑ Self ❑ Spouse ❑ Child ❑ Other _____	Subscriber's Employment Status ❑ Full Time ❑ Part Time ❑ Unemployed	Subscriber's Employer

IN CASE OF EMERGENCY

Name of local friend or relative to contact	Relationship to patient	Home Phone ( )	Alternate Phone ( )

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize The Miriam Hospital (Women's Medicine Collaborative) or insurance company to release any information required to process my claims.

Patient/Guardian signature	Date

PATIENT PORTAL: Would you like access to the Women's Medicine Collaborative Patient Portal? ❑ Yes ❑ No
ADVANCED DIRECTIVES: Do you have a Living Will? (A written document instructing your attending physician to withhold or withdraw life-sustaining procedures in the event of a terminal condition) ❑ Yes ❑ No Do you have a Durable Power of Attorney for Healthcare? (A written declaration by the patient designating another person to be the patient's agent) ❑ Yes ❑ No I would like the *Living Will and Durable Power of Attorney for Healthcare* booklet. ❑ Yes ❑ No

Women's Medicine Collaborative
A program of The Miriam Hospital
A Lifespan Partner

Patient Label

We want to make sure that all our patients get the best care possible. Please tell us your country of origin and racial/ethnic background so that we can review the treatment that all patients receive and make sure that everyone gets the highest quality of care. Your answers are confidential and will have no effect on the care you receive.

ETHNICITY – PLEASE CIRCLE YOUR ETHNICITY
Hispanic or Latino
Non Hispanic/Latino
RACE - PLEASE CIRCLE YOUR RACE
White
Black (includes Black, African American, African, Ethiopian, Ghanaian; Haitian, Cape Verdean, West Indian, Nigerian, Other African)
Native Hawaiian/Pacific Islander (includes Native Hawaiian, Pacific Islander, Guamanian)
American Indian or Alaskan
Asian (includes Chinese, Cambodian, Hmong, Indian, Filipino, Laotian, Other Asian)
Multi Racial
White and Black
White and Asian
White and American Indian or Alaskan
White and Native Hawaiian/Pacific Islander
Black and Asian
Black and American Indian or Alaskan
Black and Native Hawaiian/Pacific Islander
Asian and American Indian or Alaskan
Asian and Native Hawaiian/Pacific Islander
Other

Registrar's SMS ID_____
Every patient is to complete this form once. Registrar will scan form into DI.

Rev. 12/2014

Patient Label

Women's Medicine Collaborative
A program of The Miriam Hospital
A Lifespan Partner

In our efforts to protect your privacy, please let us know how you would like us to reach you regarding future appointments or information regarding your healthcare.

HOME (____) _____
Please provide HOME telephone number

- May we leave a message about your next appointment date and time? _Y _N
- May we leave a message on your home answering machine/voicemail? _Y _N
- May we leave a message with anyone who answers your home phone? _Y _N
- May we leave a message regarding the following:
  - Test results? __Y __N
  - Asking you to call us back? __Y __N

WORK (____) _____
Please provide WORK telephone number

- May we call you at work? __Y __N
- May we leave a message about your next appointment date and time? _Y _N
- May we leave a message on your voicemail at work? __Y __N
- May we leave a message with anyone who answers your phone at work? __Y __N
- May we leave a message regarding the following:
  - Test results? __Y __N
  - Asking you to call us back? __Y __N

OTHER (____) _____ _____
Please provide other telephone number Please specify (cell, family member, etc.)

- May we leave a message about your next appointment date and time? _Y _N
- May we leave a message regarding the following:
  - Test results? __Y __N
  - Asking you to call us back? __Y __N

_____
Print Name

_____ _____
Patient Signature Date