DELMED HEALTH
WOMEN'S HEALTH SERVICES

DelMed Health

431 Savannah Rd. 1st Floor
Lewes, DE 19958
Phone: (302) 644-9080 Fax: (302) 644-9088

Please Print and Complete All Information

Last Name: _____ First Name: _____ Middle Initial: _____

Social Security: _____ DOB: _____ E-Mail: _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Primary Phone: _____ Secondary Phone: _____ Other: _____

Employer: _____ Employer's Phone: _____

Preferred Pharmacy: _____ City: _____ Phone: _____

Emergency Contact: _____ Phone: _____

Preferred Language: _____ Primary Care Physician: _____

Ethnicity: Hispanic / Latino Non Hispanic / Latino Refused to Report / Unreported

Race: White American Indian Asian African American Hispanic Native Hawaiian Other

Marital Status: Single Divorced Married Separated Widowed Partner

Primary Insurance: _____ Co-Payment: _____

Subscriber Name: _____ Relationship: _____ DOB: _____

Social Security: _____ ID Number: _____ Group Number: _____

Secondary Insurance: _____ Co-Payment: _____

Subscriber Name: _____ Relationship: _____ DOB: _____

Social Security: _____ ID Number: _____ Group Number: _____

I give my permission for the following people to have copies or access to my Protected Health Information.

Parent / Legal Guardian: _____ Phone: _____

Spouse / Partner: _____ Phone: _____

Other: _____ Phone: _____

Primary Care Physician: _____ Phone: _____

If any other Medical Provider contacts DelMed Health pertaining to my medical care, I give my permission for DelMed Health to discuss and or release any and all medical records to them that would be of benefit for my health care.

Patient Signature: _____ Date: _____

Responsible Parent / Legal Guardian: _____ Date: _____