INTEGRATIVE FAMILY MEDICINE, LLC

10440 Shaker Drive, Ste 103, Columbia, MD 21046 ❑ Of/Fx: 888-953-0005 ❑ ifm@onebox.com ❑ www.mdfamilyphysician.com

COVER SHEET

Full Name ____ **Middle Initial** _____ **DOB** _______________

Contact Information

	Use First	Authorized to leave messages with Medical Information on:
Cell ____________________________________	❑	❑
Home ____________________________________	❑	❑
Work ____________________________________	❑	❑
Email ____________________________________	❑	❑

Address: ____

Emergency Contact

Full Name	Relationship	Phone

Other individuals you authorize me to discuss your medical care with (partner, mother, son, etc):

Full Name	Relationship

Advance Directives: Do you have Advance Directives/Medical Will (if not, see www.fivewishes.org)? ☐ Yes ☐ No
Is your family or benefactor aware of them and where they are kept? ☐ Yes ☐ No
Do you have a personal Power of Attorney? ☐ Yes ☐ No
Name:____

Pharmacy ***(if applicable) Name & Phone:***____ Prefer ☐ 1 ☐ 3 mo supply

Insurance ***(Although I do not participate with insurance companies, this information may be needed for you to submit for possible reimbursement, etc)***

Insurance Company Name		**Relationship (if different)**	
Name of Insured (if different)		**Member Number**	
DOB of Insured (if different)		**Group Number**	

Providers ***It is advised you have a primary medical provider in addition to my consult services. Please list your provider, including any other practitioners you're currently seeing (GI Doctor, Chiro, Acupuncturist, etc)***

Name	Specialty	Address	Phone

Signature	**Printed Name**	**Date**