Welcome to Windhaven Adolescent & Sports Medicine!

We are different kind of primary care practice, focusing on the unique health and wellness issues of teens and young adults. We care for patients during their teens and twenties and offer primary and specialty/consult care.

Dr.Scalfano is passionate about providing excellent care to Teens and Twenties. Her visits allow for more than 3x the average physician visit in order to thoroughly assess the patient's needs and develop a treatment or health-maintenance plan that is effective and practical.

If you/your son/daughter has been referred to us by their primary care physician or healthcare provider, you should still receive primary care from that person but we may see you in conjunction with them for a specific issue.
If you/your son/daughter is coming to our practice to establish as primary care patient of Dr.Scalfano, please let us know that when making your initial appointment.

The following forms should be completed prior to your first appointment. **Please complete these word documents and return to the secure email through which you received them OR fax them back to (731) 201-5756.**

Please see our website for maps/directions to our several office locations. Contact instructions can be found there or you can contact us through your chart portal as soon as you have an established chart.

We look forward to meeting you!

Windhaven Adolescent & Sports Medicine

THE NEXT STEP

Patient Information
Full given name_____ Preferred name_____
DOB_____ Gender at Birth_____
Address of residence_____
Billing address if other than above_____

If **patient is married**,
name of spouse_____ phone_____

If **patient is a MINOR,** name and relationship of parents/guardian(s):
name_____DOB_____relation_____phone_____
name_____DOB_____relation_____phone_____
name_____DOB_____relation_____phone_____
name_____DOB_____relation_____phone_____

Patient's email_____Parents' emails_____
Patient's phone_____(even if pt is a minor)

School name if patient is a full-time student_____
Employer if patient is employed_____
Patient's siblings
_____age(s)_____

Primary Insurance Information:
Name of insurance company_____ Member ID_____
Group #_____ Policyholder's name_____DOB_____
policyholder's relation to patient_____

Emergency Contacts:
Name_____phone_____

Name and specialty of other physicians that care for the patient:

_____

_____

_____

Preferred Pharmacy
Name/Address_____

Windhaven Adolescent & Sports Medicine