J. MORRIS MCKELLAR, MD
CARTER J. MOORE, MD

ACKNOWLEDGEMENT

Patient Name:_____

Date of Birth:_____

Social Security Number:_____

I acknowledge that OB Associates/J. Morris McKellar, MD & Carter J. Moore, MD provided me with a written copy of his Notice of Privacy Practices.

_____ _____
Patient Signature Date

_____ _____
Personal Representative Signature (if applicable) Relationship to Patient

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IF THE PATIENT IS A MINOR OR STUDENT

Mother's Name_____ Date of Birth_____ SS#_____

Mother's Address _____ Phone #_____
Street City State Zip Code

Mother's Employer _____Occupation_____ Work Phone #_____

Employer's Address _____
Street City State Zip Code

Father's Name_____ Date of Birth_____ SS#_____

Father's Address _____ Phone # _____
Street City State Zip Code

Father's Employer _____Occupation_____ Work Phone #_____

Employer's Address _____
Street City State Zip Code

J. Morris McKellar, M.D., F.A.C.O.G.

Carter J. Moore, M.D., F.A.C.O.G.

O.B. Associates

304 West 20th Street ~ Mt. Pleasant, Texas 75455
Phone (903) 572-5882 ~ Fax (903) 572-7330

CONFIDENTIALITY FORM

I give my permission allowing the "Offices of Dr. J. Morris McKellar and Dr. Carter J. Moore" to discuss my medical information with the following individuals:

	Name	Relationship	Phone
1.			
2.			
3.			
4.			

May we leave a voice message at the following locations?
(If yes, provide number below)

Home _____

Work _____

Mobile _____

_____ _____
Patient or Legal Guardian Signature Relationship

_____ _____
Printed Name Date

J. MORRIS MCKELLAR, MD
CARTER J. MOORE, MD

DATE_____

PATIENT INFORMATION **REFERRED BY**_____

Name_____ Date Of Birth _____ Age_____ SS # _____

Marital Status ___ (S M W D) **Cell #**_____ **Phone #**_____

Mailing Address_____
Street City State Zip Code

Patient's Employer _____ Occupation_____ **Phone #**_____

Employer Address _____ How Long Employed_____
Street City State Zip Code

Drug Allergies_____(If none, please specify as none)

Spouse's Name_____ Spouse's Date of Birth_____ Spouse's SS #_____

Spouse's Employer_____ Occupation_____ Business Phone # _____

Employer's Address _____
Street City State Zip Code

Name of person who could reach you_____ Phone #_____

Name of relative who could reach you_____ Phone #_____

Patients who would refuse blood or blood products in a life threatening emergency should seek care elsewhere.

AUTHORIZATION FOR TREATMENT & ASSIGNMENT OF BENEFITS

I hereby authorize J. Morris McKellar, MD and/or Carter J. Moore, MD consent for treatment as he deems necessary.

COLLECTION POLICY

I understand that all charges incurred become my responsibility. Though an insurance claim may be filed, as a convenience to me, I understand that any applicable co-pays, deductibles, or co-insurance amounts are due on the same day services are rendered.

*** We accept Visa and MasterCard**

_____ _____
Signature of Patient Date