OB ASSOCIATES | OBSTETRICS AND GYNECOLOGY
J. MORRIS MCKELLAR, M.D., F.A.C.O.G.| CARTER J. MOORE, M.D., F.A.C.O.G.

REFERRED BY: _____Social Security Number: _____ - ___ - _____

Name:_____ Date of Birth: ____ / ____ / ____

Mailing Address:_____City:_____State:____Zip code:_____

Email Address: _____ Marital Status: _____(SMWD)

Cell#:_____*May we leave a text message on this number?* ____ Yes ____ No

Home#:_____ *May we leave a message on this number ?* ____ Yes ____ No

Work#: _____ *May we leave a message on this number?* ____ Yes ____ No

Drug Allergies:_____(*If none, please specify as none*) Other Allergies _____

Patient's Employer: _____Occupation:_____Work Phone#:_____

Employer Address: _____How long employed?_____

Spouse's Name:_____Employer:_____Work Phone#:_____

Emergency Contact: _____Phone#:_____Relationship:_____

INSURANCE

Primary Insurance:_____Policy#: _____Group#:_____

Policy Holder's Full Name (*The person who holds the policy*) :_____

Policy Holder's Date of Birth: ____ / ____ / ____ Relationship to Patient: _____

Secondary Insurance: _____Policy#: _____Group#:_____

AUTHORIZATION OF TREATMENT AND 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, MasterCard, and Discover cards.

****PATIENTS WHO WOULD REFUSE BLOOD OR BLOOD PRODUCTS IN A LIFE THREATENING EMERGENCY SHOULD SEEK CARE ELSEWHERE.****

_____ _____

Signature of Patient **Date**

(If you are younger than 18 years old, forms must be signed by a parent or guardian.)

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NOTICE OF PRIVACY PRACTICE PATIENT ACKNOWLEDGEMENT

I have received and/or reviewed this practice's Notice of Privacy Practices. The notices provides details about uses and disclosures of my protected health information that may be needed by this practice, my individual rights, how I may exercise these rights, and the practice's legal duties with respect to my information. I understand that this practice reserves the right to change the terms of Its Notice of Privacy Practices, and to make changes regarding all protected health information resident at, or controlled by the practice. I understand that I may obtain this practice's current Notice of Privacy Practices upon request.

RELEASE OF INFORMATION

Your doctor is not allowed to release information to anyone but the patient. If you would like our office to be able to discuss results or medical information with anyone besides yourself, please indicate below:

_____ Only to Myself

_____ Other

Name: Relationship Phone#

1. _____

2. _____

3. _____

4. _____

IF THE PATIENT IS A MINOR (YOUNGER THAN 18 YEARS OLD)

Mother's Name: _____ **Date of Birth:**____ / ____ / ____

Mailing Address:_____ **City:** _____ **State:** **Zip code:** _____

Cell#: _____ **Home#:** _____ **Work#** _____

Employer: _____**Occupation:**_____ **Employer Address:** _____

Father's Name: _____ **Date of Birth:**____ / ____ / ____

Mailing Address:_____ **City:** _____ **State:** **Zip code:** _____

Cell#: _____ **Home#:** _____ **Work#** _____

Employer: _____ **Occupation:** _____ **Employer Address:** _____

_____ _____

Signature of Patient **Date**

_____ _____

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