GREECE OBSTETRICS & GYNECOLOGY, LLP

PATIENT INFORMATION, AUTHORIZATIONS & ACKNOWLEDGEMENTS

Patient's Name______________________________________ **Maiden Name:**______________________ **DOB:** _____________

Address: ____ **City:**____________________ **State:**_________ **Zip:**___________

Telephone: (home)__________________ **(cell)**____________________ **(work)**_________________

Married____ **Single**____ **Widow**____ **Divorced**_____

Referred By:____

Your Occupation:____ **Employed By:**___________________________________

Name of Spouse:_________________ **Phone:**___________________ **Spouse's Employer:**______________________________

I authorize the release of any medical information from my physician(s) to this Practice and from the Practice to my physician(s) for continuity of care.

I authorize the release of any medical information necessary to process insurance claims and/or comply with my health plan's quality assurance reviews.

I have been offered a copy of the Notice of Privacy Practices. I can view it on your website (www.greeceobgyn.com) or request one to be emailed, faxed or mailed to me.

I understand that I am responsible for notifying the Practice if my insurance coverage changes.

CONTACTS/HIPPA
In addition to sending information via postal mail, **please circle** "Yes" or "No" to indicate how we may leave you messages regarding appointments: Home phone: Yes / No Cell phone: Yes / No Work phone: Yes / No

Emergency Contact: Name:_________________________________ Phone:______________________ Relation:_____________

COMMUNICATION OF MEDICAL RECORDS:
Whom may we speak to regarding your medical care and what we can discuss:
Everything in your chart?______ Just test results?______ Only to make/reschedule appts?_____ Financial Information?_____

Name	Relationship	Phone	**Anything specifically we CANNOT discuss?**

Patient Signature:____ **Today's Date:**___________________________