



PATIENT INFORMATION

Patient Name: Last: _____ First: _____ Middle: _____

Address: _____

City: _____ State: _____ Zip: _____ Phone: _____

Sex: _____ Race: _____ Marital Status: _____ Birthday: _____

Retired: _____ Employed: _____ Full Time Student: _____ Cell Phone: _____

Employer: _____ Phone: _____

Social Security: _____ Drivers License: _____

Person responsible for account: _____ Relationship: _____

Address: _____

City: _____ State: _____ Zip: _____ Phone: _____

Sex: _____ Race: _____ Marital Status: _____ Birthday: _____

Retired: _____ Employed: _____ Full Time Student: _____ Cell Phone: _____

Employer: _____ Phone: _____

Social Security: _____ Drivers License: _____

Spouse's Name: _____ Employer: _____ Phone: _____

Person to notify in case of emergency: _____ Phone: _____

(Outside Your Home)

Relatives of friends that are patients: _____

Drug Allergies: _____

Major Medical Problems: _____

Have you arranged for a Living Will? (Advanced Directive) Yes No Have you appointed a durable power of attorney? Yes No

INSURANCE POLICY INFORMATION

Insurance Company (Primary): _____

Policy holder's name: _____ Birthdate: _____ / _____ / _____

Employer: _____ Co-payment amount: \$ _____

Group Number: _____ Contract Number: _____

Relationship of patient to policy holder: _____

Insurance Company (Secondary): _____

Policy holder's name: _____ Birthdate: _____ / _____ / _____

Employer: _____ Co-payment amount: \$ _____

Group Number: _____ Contract Number: _____

Relationship of patient to policy holder: _____

Referred by: _____

Where did you hear about Trinity OB/GYN:

- Internet/Web Search
- Word-of-Mouth (Friend/Neighbor)
- Print Advertising
- Other (Please explain below)

Other: _____

SIGNATURE: _____ DATE: _____



Mary B. Adams, M.D.
James C. Brock, M.D.
Lindsay Killingsworth, M.D.
Wm. Andrew Lemons, Jr., M.D.
Natalie Reddington, D.O., M.P.H.
Lewis R. Schulman, M.D.

Non-Covered Service Agreement

As your physician, I want to provide you with the best care possible. There may be certain routine services performed during your visit(s), such as:

Dexa Scans	Pap Smears	Biopsies
Ultrasounds or X-rays	Lab Work	Injections

and/or other testing that I feel necessary for the maintenance of your good health and that may NOT be covered by your insurance contract. You will be expected to pay for these services.

Signature _____ Date _____

Signature _____ Date _____

Signature _____ Date _____

Signature _____ Date _____

Signature _____ Date _____

Signature _____ Date _____

Signature _____ Date _____



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Authorization for the Release of Patient Information

_____ **I DO NOT** wish to have test results or other medical information released to any person other than myself.

_____ **I DO** wish to have test results or other medical information released to the following person(s):

Name	Relationship
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Name	Relationship
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Name	Relationship
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Name	Relationship
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It is the responsibility of the patient to notify this office of any changes in the above information. If changes do occur, the patient must file another Authorization for Release of Patient Information with this clinic.

Please understand that it may be necessary for us to disclose some or all of the Information contained in your medical records to other physicians, nurses, and/or healthcare providers (collectively referred to as "providers"). At times, other providers assist using assessing a patient's condition, screening for potential problems, or providing consultation under certain circumstances. All healthcare providers are required by law to maintain your patient confidentiality.

Also, due to the increased awareness of quality care and outcome measurements, it may be necessary to disclose information regarding your care to healthcare agencies (both private and governmental), your insurance company and/or your self-insured employer. Regarding the information going to your employer, other than information needed to verify your insurance coverage, the data released will consist of statistical information only.

Patient Signature	Date
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Printed Name	SS#
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