Tennessee Valley OB-Gyn Clinic, PC

(256) 265-6512
910 Adams Street, Suite 200
Huntsville, AL 35801
Fax: (256) 265-6727

PATIENT INFORMATION

Full Name ____

Street Address ____________________ City/State ________________ Zip __________

Mailing Address (if different) ______________________________________

Home Phone ________________ Work # ________________ Cell # ________________

Date of Birth __________ Age _____ Marital Status _____ Social Security # ________________

Employer's Name & Address ______________________________________

____

Primary Care Physician Name & Address ______________________________

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Emergency Contact Name ______________________________________

Cell # ________________ Home # ________________ Relationship ________________

RESPONSIBLE PARTY INFORMATION (Insurance Policy Holder)

Full Name ____

Street Address ____________________ City/State ________________ Zip __________

Mailing Address (if different) ______________________________________

Home Phone ________________ Work # ________________ Cell # ________________

Date of Birth __________ Age _____ Marital Status _____ Social Security # ________________

Relationship to Patient ______________________________________

Employer's Name & Address ______________________________________

INSURANCE INFORMATION

Primary Insurance ____________________ Address ______________________

Subscriber Name ________________ Date of Birth __________ Policy # __________ Group # __________

Secondary Insurance ____________________ Address ______________________

Subscriber Name ________________ Date of Birth __________ Policy # __________ Group # __________

I hereby authorize and direct payment to **Tennessee Valley OB/Gyn Clinic, PC** for medical and/or surgical benefits, if any, otherwise payable to me under the terms of my insurance. I understand that I am financially responsible for the charges not covered by this authorization. I understand that checks returned for non-payment will incur a $20 processing fee.

Patient/Responsible Party Signature ______________________________ Date __________________________

I hereby authorize **Tennessee OB-Gyn Clinic, PC** to release any information acquired in the course of my examination or treatment to my insurance company for the purpose of processing claims for medical/surgical services.

Patient/Responsible Party Signature ______________________________ Date __________________________

DUE TO THE PRIVACY CONFIDENTIALITY ACT, Please list the people that you approve to have access to your information as stated below:

Appointment Scheduling ______________________________ Relationship ________________________

Billing Information ____________________________________ Relationship ________________________

Medical Records Information __________________________ Relationship ________________________

AUTHORIZATION TO LEAVE MESSAGES

I authorize **Tennessee OB-Gyn Clinic, PC** physicians and staff to leave messages regarding my medical condition, such as lab reports, other test results, medications, and appointment reminders on my home answering machine. This authorization will be in effect until I have given written notice to **Tennessee OB-Gyn Clinic, PC**.

Agree _____________________________ Disagree __________________

Signature ____ Date __________________________

AUTHORIZATION TO CONTACT AT EMPLOYMENT

I authorize **Tennessee OB-Gyn Clinic, PC** physicians and staff to leave messages reminding me of my appointment at my employment if they are unable to leave a message at my home number for any reason. I may revoke this authorization by giving written notice to **Tennessee OB-Gyn Clinic, PC**.

Agree _____________________________ Disagree __________________

Signature ____ Date __________________________