DOTHAN OBGYN, INC.

Patient Information Form

Name: _____ Age: _____

Address: _____

_____

Date of Birth: _____ Social Security No. _____

Preferred Phone number: _____ Is this a mobile? _____

Secondary Phone number: _____

Email Address: _____

Race: White _____ Black _____ Asian _____ Other: _____

Ethnicity: Hispanic/Latino: _____ Not Hispanic/Latino: _____

Preferred Pharmacy and Location: _____

Employer with Phone: _____

Insurance Company: _____

Contract Holder with date of birth: _____

Contract/Policy Number: _____

Emergency Contact Name: _____

Relationship: _____ Phone Number: _____

RELEASE OF PROTECTED HEALTH INFORMATION

My health record is private and is known under the law as Protected Health Information (PHI). By signing this form, I authorize Dothan OBGYN to share my PHI with the following individuals:

Name: _____ Date of Birth: _____

Name: _____ Date of Birth: _____

Name: _____ Date of Birth: _____

_____ _____

Patient/Representative Signature Date