

DOTHAN OBGYN, INC.
1118 Ross Clark Circle Suite 402
Dothan, AL 36301
(334)673-3633

PATIENT NAME		First	Middle	Last	Nickname
ADDRESS		City	State	Zip	
CONTACT INFORMATION Preferred Phone Number: Mobile:		DATE OF BIRTH		Race (Circle): White Black Asian Other Ethnic Group (NOT HISPANIC OR LATINO	
MARITAL STATUS	AGE	SOCIAL SECURITY NUMBER		EMAIL	
EMPLOYER		EMPLOYER ADDRESS			EMPLOYER PHONE
INSURED PARTY (Please complete if someone other than patient is responsible for insurance.)					
Name of Insured:			ADDRESS	CITY	STATE ZIP
Date of Birth (required):					
HOME PHONE: () CELL PHONE: ()		RELATIONSHIP		PREFERRED PHARMACY	
EMERGENCY CONTACT					
NAME		RELATIONSHIP		PHONE NUMBER	
REFERRAL INFORMATION					
HOW DID YOU HEAR ABOUT US?					
TELEVISION	PHONE BOOK	NEWSPAPER	RADIO	WEBSITE	
REFERRING PHYSICIAN NAME			FRIEND'S NAME		
OTHER					

PRIVACY PRACTICES ACKNOWLEDGEMENT

I HAVE RECEIVED, READ AND UNDERSTAND YOUR NOTICE OF PRIVACY PRACTICES CONTAINING A MORE COMPLETE DESCRIPTION OF THE USES AND DISCLOSURES OF MY HEALTH INFORMATION. I UNDERSTAND THAT THIS PRACTICE HAS THE RIGHT TO CHANGE ITS NOTICE OF PRIVACY PRACTICES AT ANY TIME. I MAY REQUEST IN WRITING THAT YOU RESTRICT HOW MY PRIVATE INFORMATION IS USED OR DISCLOSED TO CARRY OUT TREATMENT, PAYMENT OR HEALTH CARE OPERATIONS.

PATIENT/REPRESENTATIVE SIGNATURE: _____ DATE: _____

The following individuals are authorized for release of my personal information:

NAME:	DATE OF BIRTH: