Panama City Gynecology, LLC

SSN _____ Sex _____ Employment status _____

First _____MI _____ Last _____

DOB _____ Marital Status _____ Race _____Ethnicity _____

Address_____ Zip _____

Referring provider _____ PCP _____

Home phone _____ Mobile _____

Preferred phone? H or M OK to Text, Voice and Email? Y or N Previous COB patient? Y or N

Email _____

Insurance _____

Member ID _____GRP _____

Subscriber if different than patient _____DOB _____

Emergency Contact _____ Mobile _____

Pharmacy _____ Zip code _____

Medical Authorizations and Release of Information
Insurance Authorization and assignment. I hereby authorize PC Gynecology, LLC to furnish information to my Insurance Carrier concerning illness and treatment and herby PC Gynecology, LLC payments for medical services rendered to myself or dependents. I understand that I am responsible for any amount not covered by insurance.

Signature _____**Date** _____

Notice of Privacy Acknowledgement
I acknowledge that due to current HIPPA laws my doctor is required to obtain written consent to disclose any Private Health Information in the presence of anyone other than myself.

Please check the corresponding line:
_____ **I Allow** PC Gynecology, LLC to discuss details of my medical records/financial records with

_____ _____
please print name of authorized person relation of authorized person

_____ **I Do Not Allow** PC Gynecology, LLC to discuss details of my medical records/financial with anyone else but me.

Signature _____**Date** _____