Greenville OB-Gyn Clinic

3900 Joe Ramsey Blvd. Bldg E. Greenville, Tx 75401

(903) 454-1722

Dr. Marie Hollis,M.D., Heather Kent, CNM, Kimberly Parks, MSN, RN, CNM, Pamela Wyatt, MSN, CNM, WHCNP-C
Sarah Harville, WHNP-BC

Patient Intake information

Name:____
First MI Last

SS#:________________________ Birthday__________________

Address:______________________________City____________State__________Zipcode_____

Home Phone:________________ Cell Phone:______________ Work Phone:__________________

Email:______________________________ Referring Physican:__________________________

Marital Status:_______ Race:_______ Ethnicity:_______ Preferred Language:__________________

Employer:_____________________________ Occupation:______________________________

Emergency Contact:____________________ Relationship:__________ Phone Number:_____________

Spouse:______________________________ Spouse Date of Birth:__________________________

Phone Number:________________________ Spouse Work#:_____________________________

Insurance Information

Insurance Company:________________________ Policy#:______________________________

Group#:_______________________________ Copay:__________________________________

Name of Insured:___________________________ Insured's DOB:_________________________

Relationship to patient:_______________________ Employer:___________________________

Insurance Address:__________________________ Phone#:______________________________

Secondary

Name of Insurance:_________________________Policy#:_________________________________

Group#:_______________________________ Copay:__________________________________

Name of Insured:___________________________ Insured's DOB:_________________________

Relationship to patient:_______________________ Employer:___________________________

Insurance Address:__________________________ Phone#:______________________________

Marie Hollis, M.D., Heather Kent, CNM, Kimberly Parks, MSN, RN, CNM, Pamela Wyatt , MSN, CNM, WHCNP-C
Sarah Harville, WHNP-BC

I authorize and direct ______________________________ to examine me and perform those procedures necessary for prenatal and/or family planning care and/or women's healthcare and/or general medical care. Procedures that may be performed include, but are not limited to:

- Medical history and physical examination, including pelvic and breast examination
- Blood draws to screen for syphilis, anemia, rubella, diabetes, hepatitis, and AIDS or HIV, and other blood work determined to be necessary.
- Urinalysis, urine pregnancy tests, urine culture, and drug screens
- Gonorrhea/Chlamydia culture and pap smear
- Other appropriate lab work
- Ultrasound
- Necessary immunizations

The nature of the procedures has been explained to me and no warranty or guarantee has been made to me as to the result.

I understand that medical providers of the OB-Gyn clinic who will be examining me include physicians, certified nurse midwives, advanced nurse practitioners and physician assistants.

- Advanced nurse practitioners are professional nurses educated to provide the full range of primary care services in the community and hospital settings. They are certified by the American Nurses Association or by nursing specialty organizations. They hold licenses from the state as Registered Professional Nurse Practitioners.
- Physician Assistants are skilled members of the health care team who are educated to work dependently with physicians and under their supervision provide diagnostic and therapeutic patient care.
- Certified Nurse Midwives are individuals educated in the two disciplines of nursing and midwifery, who possess certification according to the requirements of the American College of Nurse Midwives. In addition, in the state of Texas, they hold license as Registered Nurses and Advanced Nurse Practitioners.

I understand that I may request to be seen by a physician.

Additionally, the OB-Gyn Clinic employs or contracts with other professionals to provide some of the services offered as part of our treatment team. These individuals provide ancillary or allied health services such as sonography, phlebotomy, and psychotherapy. I understand that as part of my assessment or treatment at the OB-Gyn clinic, qualified professionals, may provide, at the request of my medical practitioner, ancillary or allied health services important to my care.

I authorized release of any medical information required for payment of my provider (including ancillary or allied health services) and/or hospital charges for services rendered by the OB-Gyn clinic or by one of its providers or allied health practitioners. I further authorized release of information to any hospital or medical facility I present myself to medical care.

Patient Name:______________________________

Patient's Signature:______________________________ Date:______________

Guardian's Signature:______________________________ Date:______________

ACKNOWLEDGEMENT OF REVIEW OF NOTICE OF PRIVACY PRACTICES

I have reviewed this office's Notice of Privacy Practices, which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of this document.

____

Signature of Patient or Personal Representative

____

Date

____

Name of Patient of Personal Representative

____

Description of Personal Representative's Authority

Yo revisado la Noticia de Practicas Privadas de su oficina que me explica como podra ser usada y divulgada mi information medica. Yo entiendo mis derechos a recibir una copia de este document.

____

Firma del Paciente o Representate Personal

____

Fecha

____

Nombre de Paciente o Representante Personal

____

Description de Autoridad de Representante Personal

ACKNOWLEDGEMENT OF REVIEW OF NOTICE OF PRIVACY PRACTICES

I have reviewed this office's Notice of Privacy Practices, which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of this document.

____

Signature of Patient or Personal Representative

____

Date

____

Name of Patient of Personal Representative

____

Description of Personal Representative's Authority

Yo revisado la Noticia de Practicas Privadas de su oficina que me explica como podra ser usada y divulgada mi information medica. Yo entiendo mis derechos a recibir una copia de este document.

____

Firma del Paciente o Representate Personal

____

Fecha

____

Nombre de Paciente o Representante Personal

____

Description de Autoridad de Representante Personal