NOVAS, DOHR & COLL OB/GYN ASSOCIATES, S.C.

Patient Information & Disclosure of Test Results

LAST NAME	FIRST NAME	MI	MAIDEN NAME

EMAIL	SOCIAL SECURITY #	SEX	DATE OF BIRTH

ADDRESS	CITY	STATE	ZIP

MARITAL STATUS	IF MINOR, WHO IS RESPONSIBLE PARTY?	HOME PHONE	WORK PHONE	CELL PHONE

FAMILY DOCTOR & PHONE NUMBER	PRIMARY PHARMACY ADDRESS & PHONE NUMBER	OCCUPATION

ETHNICITY: (Please circle one)	Non-Hispanic Hispanic Refused to Report	PRIMARY RACE: (Please circle one)	White Hispanic African American	Asian Native American Native Hawaiian	Other Pacific Islander Other Race Unreported/Refused

INSURED INFORMATION (Primary) (Who is coverage through?)

LAST NAME	FIRST NAME	MI	DATE OF BIRTH	SEX	RELATIONSHIP	SSN#

EMPLOYER NAME & ADDRESS	TELEPHONE NUMBER	INSURANCE COMPANY NAME & ADDRESS

INSURANCE TELEPHONE NUMBER	PERSONAL ID#	GROUP #

INSURED INFORMATION (Secondary) (Who is coverage through?)

LAST NAME	FIRST NAME	MI	DATE OF BIRTH	SEX	RELATIONSHIP	SSN#

EMPLOYER NAME & ADDRESS	TELEPHONE NUMBER	INSURANCE COMPANY NAME & ADDRESS

INSURANCE TELEPHONE NUMBER	PERSONAL ID#	GROUP #

IN CASE OF EMERGENCY – PLEASE NOTIFY

LAST NAME	FIRST NAME	RELATIONSHIP	HOME PHONE	WORK PHONE	CELL PHONE
LAST NAME	FIRST NAME	RELATIONSHIP	HOME PHONE	WORK PHONE	CELL PHONE

DISCLOSURE OF TEST RESULTS – Please choose from the following options:

_____ I want my test results/healthcare reported only directly to me.

_____ Novas, Dohr & Coll Ob/Gyn Associates, S.C. has my permission to speak to any of the individuals listed below:

NAME	RELATIONSHIP	TELEPHONE
1.		
2.		

May we leave information on your voicemail/answering machine? _____YES _____NO
May we call you at work? _____YES _____NO
May we call you on your cell? _____YES _____NO

Signature: _____ Date: _____