Directions: to fill out form, download the file to your desktop or downloads folder.
To download: click Browser Menu -> File -> Save or Export as PDF.

PATIENT INFORMATION

LAST NAME: ______________________ FIRST NAME: ______________________ MI: ______

ADDRESS: ______________________ CITY: ____________ STATE: ______ ZIP: ______

HOME PHONE: ______________________ WORK PH: ______________ CELL: ______________

YOUR EMAIL ADDRESS: ____

- IS IT OK TO RECEIVE MESSAGE/EMAIL REMINDERS ABOUT YOUR APPOINTMENTS? ________

SEX: __M __F MARITAL STATUS: __M __S __D __W DATE OF BIRTH: ____________ AGE: ______

SOCIAL SEC. #: ______________ EMERGENCY CONTACT NAME & NUMBER: ______________
(Someone that does not live with you)

EMPLOYER NAME & ADDRESS: ____

HOW DID YOU HEAR ABOUT US: ____

****

GUARANTOR INFORMATION (ONLY IF PATIENT IS UNDER AGE 18)

NAME: ______________________

ADDRESS: ______________________

CITY: ________ STATE: ______ ZIP: ______

EMPLOYER NAME & ADDRESS:

____

DOB: ______________ SEX: _____ M _____ F

SOCIAL SEC. #: ______________________

MARITAL STATUS: ___M ___S ___D ___W

SPOUSE INFORMATION

NAME: ______________________

DATE OF BIRTH: ______________________

EMPLOYER NAME & ADDRESS: ______________________

____

REFERRING PHYSICIAN: ______________________

ADDRESS (CITY & STATE): ______________________

____

****

INSURANCE INFORMATION:

*** DATE OF BIRTH OF POLICYHOLDER REQUIRED FOR INSURANCE TO PAY CLAIMS ***

PRIMARY INS: ______________ GROUP#: ____________ CONTRACT#: ______________

POLICYHOLDERS NAME: ______________ POLICYHOLDERS DATE OF BIRTH: ______________

SECONDARY INS: ______________ GROUP#: ____________ CONTRACT#: ______________

POLICYHOLDERS NAME: ______________ POLICYHOLDERS DATE OF BIRTH: ______________

****

MEDICAL INFORMATION RELEASE CONTRACT AND PROMISSORY NOTE:

I hereby authorize the release of medical information to my insurance company or their agent. I authorize any insurance company, attorney or other agent acting on my behalf to pay directly to Feagin & Owen, M.D., P.C. and benefits due as a result of treatment by any agent of the aforementioned corporation. We understand, that for services rendered or to be rendered, the undersigned promise to pay to the order of Feagin & Owen, M.D., P.C. the total charge as deemed necessary and responsible by him or his agent. There will be a 12% annual finance charge compounded monthly on all unpaid balances. The undersigned may prepay this without a penalty. In the event any payment due hereunder is not paid when due, the entire balance shall be immediately due upon demand of any holder. Upon default, the undersigned shall pay all reasonable attorney fees and cost necessary for the collection of this note. Furthermore, the undersigned agree to waive all rights of exemption under Alabama state law.

SIGNATURE OF PATIENT OR GUARANTOR: ______________________ DATE: __________

SIGNATURE OF SPOUSE OF PATIENT OR GUARANTOR: ______________________ DATE: __________

********************PLEASE ANSWER ALL QUESTIONS ON NEXT PAGE *****************

IT IS VERY IMPORTANT THAT YOU ANSWER ALL OF THE FOLLOWING QUESTIONS

LIST THE PROCEDURE/SURGERY THAT YOU ARE SEEING THE DOCTOR FOR TODAY:__________

____

****ARE YOU CURRENTLY TAKING ANY DIET PILLS?****** _________YES _________NO
IF SO, LIST THE MEDICATION: ____________________________

****

PRESENT MEDICATIONS & DOSAGES:

MEDICATIONS	DOSAGES
____________	____________
____________	____________
____________	____________
____________	____________
____________	____________

PREVIOUS OR CURRENT MEDICAL PROBLEMS NOT LISTED: ______________________________

____

PLEASE CHECK IF YOU HAVE OR HAVE A HISTORY OF ANY OF THE FOLLOWING:

☐ HISTORY OF MRSA ☐ DIABETES ☐ HIGH BLOOD PRESSURE ☐ PSYCHIATRIC ILLNESS
☐ HEART PROBLEMS ☐ BLEEDING PROBLEMS ☐ LIVER PROBLEMS

DO YOU TAKE ANY OF THE FOLLOWING? ☐ ASPIRIN ☐ VITAMIN E ☐ HERBAL PRODUCTS

ALLERGIES OR ADVERSE REACTIONS TO MEDICATIONS: ______________________________

____

LIST LATEX / LATEX PRODUCTS ALLERGY AND TYPE OF REACTION: ____________________

____

DOES YOUR OCCUPATION INVOLVE FREQUENT USE OF LATEX PRODUCTS: ☐ YES ☐ NO
IF YES, HAVE YOU EVER HAD A REACTION TO THEM? ☐ YES ☐ NO

PREVIOUS OPERATIONS AND DATES:

OPERATIONS	DATES
____________	____________
____________	____________
____________	____________
____________	____________
____________	____________

*DO YOU CURRENTLY SMOKE? _______ YES ______ NO HOW MUCH? ____________
HAVE YOU EVER SMOKED? ____________ HOW LONG DID YOU SMOKE? ______________
WHEN DID YOU STOP? ________________
*DO YOU CONSUME ALCOHOL? _______ YES ______ NO
IF YES, HOW OFTEN ____________________ HOW MUCH __________________
*HAVE YOU EVER HAD A PROBLEM DRINKING TOO MUCH? _______YES ______NO

HIPPA INFORMATION

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION MAY BE USED, DISCLOSED, AND HOW TO GET ACCESS TO THIS INFORMATION. PLEASE READ IT CAREFULLY.

COMPLETE ATTACHED PAGE AND RETURN TO STAFF

If you have any questions about this notice, please contact our Privacy Officer, Yvette Smith at 334-793-7211.

This is a summary of our Notice of Privacy, which describes how we may use and disclose you protected health information to carry out treatment, payment healthcare operations and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information and to provide you with a notice of you legal duties and privacy practices with respect to protected health information.

We are required to abide by the terms of this Notice of Privacy practices. We may change the terms of our notice, at any time, and reserve the right to do so. This notice will be affected for all protected health information that we maintain at this time.

We will use your protected health information as part of rendering care, including treatment, payment and health care options.

Other uses and disclosures of your protected health information will be made only with your written authorization, unless otherwise permitted or required by law. You may revoke this authorization at any time in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

We may use or disclose your protected health information in certain situations without you authorization or opportunity to agree or object.

You have the right to request a restriction of your protected health information. You have the right to request to receive confidential communications of your protected health information. You have the right to inspect and request a copy of your protected health information and understand there may be a charge for copying this information. You have the right to amend your protected health information. You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information. You have the right to obtain a copy of this notice from our office. You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our Privacy Officer of you complaint. We will not retaliate against you for filing a complaint.

PRIVACY NOTICE ACKNOWLEDGEMENT

FEAGIN & OWEN, M.D., P.C.

I, the undersigned, acknowledge that I have received a copy of the Notice of Privacy

____________________________________ ________________________

SIGNATURE OF PATIENT DATE

AUTHORIZATION

It is the policy of this office to maintain strict confidentially concerning the care and / or treatment received here. However, there are times and circumstances in which you may wish for us to speak with someone else about these matters. Do we have permission to:

Leave a message on your answering machine?	_____ Yes	_____ No
Send Emails/Texts confirming appointments?	_____ Yes	_____ No
Call you at work?	_____ Yes	_____ No
Leave a message at your place of employment?	_____ Yes	_____ No
Discuss your medical information with your emergency contact?	_____ Yes	_____ No
Discuss your medical information with any other family member or friend? (IF YES, PLEASE LIST BELOW)	_____ Yes	_____ No

Name: ________________________________ Relationship: __________________

Phone#: ________________________

Name: ________________________________ Relationship: __________________

Phone#: ________________________

Name: ________________________________ Relationship: __________________

Phone#: ________________________

Name: ________________________________ Relationship: __________________

Phone#: ________________________

Federal regulations allow us to disclose protected health information from your record in order to provide treatment to you, to obtain payment for the services and for other professional activities known as "health care operations" (for example, sending your medical records to other physicians).

This consent is voluntary; you may refuse to sign it. However we are permitted to refuse to provide healthcare services if this consent is not granted, or if the consent is later revoked.

I hereby consent to the use or disclosure of my protected health information as specified above.

____________________________________ ________________________

Print Name Date of Birth

____________________________________ ________________________

Signature of Patient Date Signed

Click Here to Submit these forms to Feagin & Owen