

Randy D. Proffitt, M.D.

Date: _____ Chart No.: _____
Name: _____

First Name Middle Name Last Name

Address: _____
Street City State Zip Code

Social Security No.: _____ Gender: M or F Birth date: _____ Age: _____

Marital Status: _____ Spouse Name: _____

Parent's Name: (If patient is a minor): _____

Home Phone: _____ Work Phone: _____ Mobile Phone: _____

Email: _____

Emergency Contact: _____ Relation: _____ Phone: _____

Employer: _____

Address: _____

Referring Physician: _____ (First Name) _____ (Last Name) _____

Primary Care Physician: _____ (First Name) _____ (Last Name) _____

Gynecologist: _____ (First Name) _____ (Last Name) _____

If Accident – Date of Injury: _____

Primary Insurance: _____ Policy #: _____ Group #: _____

Copay Amount: _____

Mailing Address of Insurance Company: _____

Name of Insured: _____ Birth date: _____ M or F

Social Security No. of Insured: _____ Employer: _____

Secondary Insurance: _____ Policy #: _____

Group #: _____

Mailing Address of Insurance Company: _____

Name of Insured: _____ Birth date: _____ M or F

Social Security No. of Insured: _____ Employer: _____

I hereby authorize Dr. Randy D. Proffitt, M.D. to release to my insurance company or its representative, any information including the diagnosis and the records of any treatment or examination rendered to me during the period of such medical or surgical care. I also authorize and request the insurance company to pay directly to the above name doctor the amount due me in my pending claim for basic medical, major medical and/or surgical treatment or service, by reason of such treatment or services rendered to me. In accordance with my insurance contract, I agree to be held responsible for any medical fees which my insurance company considers medically unnecessary or which they do not pay to failure on my part to meet my deductible.

In consideration for the services performed, for the undersigned or any person listed on this form, the undersigned agrees to pay the reasonable charges therefore and for the collection of said charges, undersigned hereby waives all claims or rights of exemption allowed by the constitution and laws of the State of Alabama or any other state and further agrees to pay all costs of collection of said charges including a reasonable attorney's fee. This authorization covers all hospital, outpatient, or clinic services rendered in the future whether as a result of initial or successive admissions or treatment until revoked in writing. Such written revocation shall not affect services already performed or to be performed after any admission to the hospital or clinic until patient is dismissed.

Signature: _____ Date: _____

INSURED PERSON / PATIENT
(PARENT IF PATIENT IS A MINOR)

MEDICAL INFORMATION

Please Print

NAME _____

BIRTHDATE: _____ SOCIAL SECURITY NO. _____

TODAY'S DATE: _____

For your benefit it is necessary that you answer these questions as accurately as possible so that we can determine your physical condition before undergoing surgery.

1. DO YOU HAVE: YES NO

Heart Disease YES NO

High Blood Pressure YES NO

Diabetes YES NO

Epilepsy YES NO

Thyroid Disease YES NO

Asthma YES NO

Shortness of Breath YES NO

Dizzy Spells YES NO

Swelling of Ankles YES NO

Chest Pain YES NO

Prolonged Bleeding YES NO

Jaundice YES NO

Bruise Easily YES NO

Glaucoma YES NO

Miscarriage YES NO

2. DO YOU TAKE: YES NO

Herbal Medicines YES NO

Blood Thinner Medication YES NO

Heart Medication YES NO

High Blood Pressure Med YES NO

Diuretics (water pills) YES NO

Aspirin YES NO

Diet Pills YES NO

Birth Control Pills YES NO

3. SMOKING YES NO

YES NO

4. DO YOU TAKE, OR HAVE YOU EVER TAKEN STEROIDS (CORTISONE, ETC.)

YES NO

YES NO

5. ARE YOU ALLERGIC TO: YES NO

Penicillin YES NO

Local Anesthetic YES NO

Other Drugs (please list) YES NO

6. LIST OPERATIONS YOU HAVE HAD:

AND ANY COMPLICATIONS

_____ Date: _____

_____ Date: _____

_____ Date: _____

7. LIST MEDICATIONS YOU TAKE:

8. PLEASE LIST ANY UNUSUAL MEDICAL PROBLEMS:

9. ARE SECOND OPINIONS OR PRE-DETERMINATIONS REQUIRED BY YOUR INSURANCE?

YES _____ NO _____

Request for Release of Medical Information

This signed and dated form allows Dr. Proffitt to obtain medical information from other physicians and/or other health care providers participating in my care. This form also allows Dr. Proffitt to release medical information to such providers as he deems necessary. I hereby authorize **Randy D. Proffitt, M.D., F.A.C.S.** to release/disclose to the entity stated below all medical records for all dates of care, contained within the record. I understand that all medical information regarding my treatment may be released. The releaser, its agents and employees are hereby relieved of any responsibility or liability that may arise from the release, faxing or reproduction of such records and/or information.

I understand that this consent is revocable, except to the extent that action has already been taken. Request for revocation of this authorization must be in writing to the Medical Record Department. This authorization will expire in one year.

This signed and dated form allows for the release of medical records and request they be sent to:

Randy D. Proffitt, M.D., F.A.C.S.
6317 Piccadilly Square Drive
Mobile, Alabama 36609
Phone (251) 344-0332
Fax (251) 344-0395

Date: _____

Patient's Name: _____ Date of Birth: _____

Signature of Patient: _____

Signature of Witness: _____

Authorization to Release Information

This signed and dated form allows **Dr. Randy Proffitt** and his staff to release medical information to the individuals named below involved in your medical care. Other than the named person, we will not discuss anything related to your care with anyone if they are not listed in this release. The only exception is the other medical professionals and their offices/facilities as necessary to provide you with medical care as well as your insurance company.

Person(s) with whom you *would like* your medical history, test results, appointments, etc. discussed (example: spouse, children, and friends):

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

or

_____ Please check if you would not like your care discussed with family members or friends.

Patient's Signature: _____ Date of Birth: _____

Randy D. Proffitt, M.D., LLC

Patient Consent for Use and Disclosure of Protected Health Information Authorization of Benefits

I give permission to **Randy D. Proffitt, M.D., LLC** to submit full medical records, within discretion, to my insurance companies if they so request and to other physicians that I am consulting if they so request.

I give permission to **Randy D. Proffitt, M.D., LLC** to disclose information concerning medical findings and treatment, from the initial visit until the date of conclusion of such treatment to those individuals who, by the sole determination of **Randy D. Proffitt, M.D., LLC** are required to receive such information for the purpose of medical treatment, medical quality assurance and peer review.

I hereby authorize any payment due on my claim to be paid directly to **Randy D. Proffitt, M.D., LLC**. In addition, I agree to pay for the services I received which are not covered by my medical insurance. (These services may include elective cosmetic procedures)

With my consent, **Randy D. Proffitt, M.D., LLC** may use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). Please refer to **Randy D. Proffitt, M.D., LLC** Notice of Privacy Practices for a more complete description of such uses and disclosures.

I have the right to review the Notice of Privacy Practices prior to signing this consent. **Randy D. Proffitt, M.D., LLC** reserves the right to revise its Notice of Privacy Practices at anytime. A revised Notice of Privacy Practices may be obtained by forwarding a written request to **Randy D. Proffitt, M.D., LLC** Privacy Officer at 6317 Piccadilly Square Drive, Mobile, AL 36609.

With my consent, **Randy D. Proffitt, M.D., LLC** may call my home or other designated location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out treatment, payment and healthcare operations, such as appointment reminders, insurance items and any calls pertaining to my clinical care.

With my consent, **Randy D. Proffitt, M.D., LLC** may mail to my home or other designated location any items that assist the practice in carrying out treatment, payment and healthcare operations, such as appointment reminder cards and patient statements as long as they are marked Personal and Confidential.

By signing this form, I am consenting to **Randy D. Proffitt, M.D., LLC**'s use and disclosure of my PHI to carry out treatment, payment and healthcare operations.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, **Randy D. Proffitt, M.D., LLC** may decline to provide treatment to me

Signature of Patient

Date

