Ferns, Matile, Perryman & Moore, M.D.'s, P.C.
Obstetrics & Gynecology

Patient Authorization Questionnaire

Can confidential messages be left on your voicemail? _____ **CIRCLE: Cell Home Work**

If billing address is different than physical address listed please provide:

Address: _____ City: _____ State: _____ Zip: _____

Do you want all correspondence from our office sent in a sealed envelope marked "CONFIDENTIAL"?

_____YES _____NO

Emergency Contact (Required)

Name: _____ Relation: _____ Phone #: (___) _____

Please list family members or other persons whom we may inform about selected matters:

Name: _____ Relation: _____ Phone #: (___) _____

Please circle all matters this person is authorized for:

Treatment Payment Health care Operations Billing Statements Insurance Information

Appointments Results All Matters

Name: _____ Relation: _____ Phone #: (___) _____

Please circle all matters this person is authorized for:

Treatment Payment Health care Operations Billing Statements Insurance Information

I understand and authorize the above information:

Print Patient Name: _____ **DOB:** _____

Signature _____ **Date:** _____

Or:

Parent/Guardian Name: (If Applicable) _____ **DOB:** _____

Parent/Guardian Signature _____ **Date:** _____

If patient is under 18 years of age