



# James T. Martin, Jr., MD Obstetrics & Gynecology

Becky Miller, PA-C • Martha Green, PA-C

FOR OFFICE USE ONLY:

Patient ID: \_\_\_\_\_

Date of Visit: \_\_\_\_\_

Social Security Number: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Date of Birth: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

Last name: \_\_\_\_\_ First name: \_\_\_\_\_ MI: \_\_\_\_\_ Preferred Name: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip code: \_\_\_\_\_

Home phone: ( ) \_\_\_\_\_ Cell phone: ( ) \_\_\_\_\_ Email: \_\_\_\_\_

Race: \_\_\_\_\_ Marital Status: Single - Married - Divorced - Separated - Widow

Student Status: None - Full Time - Part Time Employment Status: Not Employed - Full Time - Part Time - Retired

Employer Name: \_\_\_\_\_

Work Phone: ( ) \_\_\_\_\_ - \_\_\_\_\_ Ext. \_\_\_\_\_ OK to Call? Yes \_\_\_\_\_ No \_\_\_\_\_

Spouse's Name and/or Legal Guardian's Name: \_\_\_\_\_ SSN: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ DOB: \_\_\_\_\_

Spouse and/or Legal Guardian's Employer: \_\_\_\_\_ Work Phone: ( ) \_\_\_\_\_ - \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone: ( ) \_\_\_\_\_

Referred by: \_\_\_\_\_ Primary Doctor: \_\_\_\_\_ Pharmacy & Phone# \_\_\_\_\_

### Primary Insurance Information:

Insured's Relationship to Patient: \_\_\_\_\_

Insurance Company Name: \_\_\_\_\_ Policy Number: \_\_\_\_\_

Policy Holder: \_\_\_\_\_ SS# \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Date of Birth: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

### Secondary Insurance Information:

Insured's Relationship to Patient: \_\_\_\_\_

Insurance Name: \_\_\_\_\_ Policy Number: \_\_\_\_\_

Policy Holder: \_\_\_\_\_ SS# \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Date of Birth \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

### INSURANCE AUTHORIZATION AND ASSIGNMENT

I do hereby authorize D. James T. Martin, Jr., M.D. and/or staff to furnish information to insurance carriers concerning my illness and treatment and I hereby assign to the physician(s) all payments for medical services rendered to myself or my dependents. I understand that I am to immediately notify Dr. James T. Martin's office if any changes occur in my insurance. Payment is expected at time/date of service. I understand that Dr. James Martin's office does not file Medicaid as a secondary insurance.

All professional services rendered are charged to the patient. There will be a charge of \$10.00 for NSF checks if turned over to a collection agency. If not turned over to a collection agency, you will be charged \$35.00 for an NSF check. If surgery or in-office surgical procedures are indicated, the patient is responsible for paying in-advance and in full before any procedure is done. In the event of Surgery/Procedure needing scheduled, we will reschedule your surgery/procedure 1 time with a valid excuse. After this there could be a minimum fee of \$50.00 applied to your account, which would be patient responsibility. Necessary forms will be completed to expedite insurance carrier payments. The patient is responsible for all fees, regardless of insurance coverage. It is customary to pay for services when rendered unless other arrangements have been made in advance. If this account has to be turned over to collection, the undersigned grantor (parent or guardian, if patient is a minor or going to college and of age) agrees to pay all legally allowed interest and all collection and attorney's fees. I understand that I will be responsible for any collection and/or legal fees and monthly interest accrued due to non-payment. Accrued interest rate = 18% per year. There is a \$10.00 per form fee for disability, worker-compensation, FMLA forms etc. Obtaining/copying of medical records requires a \$15.00 administration fee, 0.65 per page charge after the 15<sup>th</sup> page and postage will be expected when records are released. Dr. James Martin's office requests a 24 hour cancellation notice of a scheduled appointment, without prior cancellation, there may be a \$25.00 no show fee added to the patient's account. Rates/fees subject to change without notice.

I understand that insurance is filed as a courtesy and that any charges not covered by my insurance will be the responsibility of the above-designated person.

Patient's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

If patient under the age of 18, person financially responsible signature: \_\_\_\_\_ Date: \_\_\_\_\_

Relationship: \_\_\_\_\_



**James T. Martin, Jr., MD**  
**Obstetrics & Gynecology**

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**Compound Authorization Form**

Name of Patient: \_\_\_\_\_ Date of Birth: \_\_\_/\_\_\_/\_\_\_

**Dr. James T. Martin, Jr., MD is authorized to release protected health information about the above named patient to the entities names below. The purpose is to inform the patient or others in keeping with patient's instructions.**

\_\_\_\_ Voice Mail and/or Answering Machine  
\_\_\_\_ For Nurse (s) to leave a message to call back for test results.  
\_\_\_\_ Other appointment, insurance, billing

\_\_\_\_ Financial  
\_\_\_\_ Medical  
\_\_\_\_ Authorized Person to Receive Information  
\_\_\_\_ Relationship

**Right of the Patient:** I understand that I have the right to revoke this authorization at any time and that I have the right to inspect or copy the protected health information to be disclosed as described in this document by sending a written notification to Dr. James T. Martin, Jr., MD.

I understand that a revocation is not effective in cases where the information has already been disclosed but will be effective going forward.

I understand that information used or disclosed as result of this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law.

I understand that I have the right to refuse to sign this authorization and that my treatment will not be conditioned on signing. This authorization shall be in effect until revoked by the patient.

**Acknowledgment of Receipt of Notice of Privacy Practice**

I have read or received a copy of Dr. James T. Martin, Jr., Notice of Privacy Practice. Initial \_\_\_\_\_

\_\_\_\_\_  
Print Name

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature (Responsible Party)

Patient Name: \_\_\_\_\_ Patient ID: \_\_\_\_\_ Date of Visit : \_\_\_\_\_

## Obstetrics and Gynecology History

### Past Medical History (check all that apply)

- Hypertension
- Hypercholesterol
- Hypothyroid
- Diabetes
- Other: \_\_\_\_\_

### Marital Status (check one)

- Single
- Married
- Separated
- Divorced
- Widowed

### Past Surgical history (check all that apply)

- Hysterectomy
- Bilateral Tubal Ligation
- Laparoscopy
- Cesarean Section
- Other: \_\_\_\_\_

### Date of Last Menstrual Period: \_\_\_\_\_

Regular or Irregular (circle one)

### Birth Control Method (check one)

- Birth control Pills
- Tubal Ligation
- Condoms
- Vasectomy
- Other: \_\_\_\_\_

### Family History (check all that apply)

- Hypertension
- Heart Disease
- Diabetes
- Cancer
- Other

### Pregnancy History (enter the appropriate #)

\_\_\_\_\_ Total Pregnancies

\_\_\_\_\_ Total Delivered

\_\_\_\_\_ Preterm

\_\_\_\_\_ Miscarriage/ Abortion

\_\_\_\_\_ Multiple

### Smoking History (check one)

- Never smoked
- Currently smoke  
Amt per day: \_\_\_\_\_
- Previously smoked  
Quit date: \_\_\_\_\_

*In the chart below, please list and give the details of any pregnancies that you have had:*

Date	Gest Age	Wt.	Sex	Type of Delivery	Place of Delivery	Complications

List any medications that you are currently taking: \_\_\_\_\_

List any allergies that you have: \_\_\_\_\_