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Muskogee, OK 74401

DavidPowellMD.com

David Powell, MD

Obstetrics/Gynecology/Cosmetic Surgery

PLEASE ANSWER ALL QUESTIONS.

PLEASE PRINT

Date last seen at this office: _____

Email Address: _____

Your SS # _____

PATIENT Name:_____
First Middle Last

Address:_____City:_____State:_____Zip:_____

Single:_____Married:_____Divorced:_____Widow:_____Separated:_____

Birthdate:_____Age:_____Race:_____

Telephone: (_____)_____Cell: (_____)_____Work: (_____)_____

Your Occupation:_____ Your Employer:_____

SPOUSES Name:_____ DOB:_____ Spouses SS:_____

SPOUSES Employer_____ Work Phone: (_____)_____

Parent or Guardian (if under 18):_____

[Nearest Friend or Relative, other than Spouse living in the Area]

Name_____Phone: (____)_____

Adress:_____City:_____State:_____ZIP:_____

Pharmacy Name:_____ Pharmacy #:(_____)_____

Referral Doctor or person referring you to this clinic:_____

Primary Care Physician (PCP):_____

Insurance

Primary Ins. Co._____ID# _____Group# _____

INSUREDS Name:_____DOB:_____ INSUREDS SS#_____

Secondary Insurance:_____ID# _____Group# _____

INSUREDS Name _____DOB_____INSUREDS SS#_____

I give my permission to release medical information to doctors and insurance companies concerned with my medical care. I hereby authorize payment directly to my physicians for this illness or injury, or the physicians or surgeons benefits otherwise payable to me, but not to exceed my indebtedness to said physician. I understand I am financially responsible to the physician for charges not covered by this assessment.

Signature:_____

NOTE: This office does not extend credit or accept post-dated checks for office visits or examinations. The fee for these services may be paid by CASH, CHECK, or CREDIT CARD when rendered. I also understand that MWC will dismiss a patient from care after missing two consecutive appointments without rescheduling.

Today's Date:_____