

Brillhart OB/GYN

James Brillhart, MD

Date: ___/___/___ DOB: ___/___/___ Chart: _____ Marital Status: M S D W

Last name: _____ First _____ Maiden name _____

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

Home phone: _____ Cell phone: _____ SSN: _____

Preferred Way to Be Contacted: Home ___ Cell ___ E-mail ___ Please List E-Mail Below:

May we leave a message with medical information? : Home: Y or N Cell: Y or N

Employer: _____ Work phone: _____

Spouse / Guardian / Partner

Last name: _____ First _____ DOB: ___/___/___

Address: _____ City _____ State _____ Zip _____

SSN: _____ Home phone: _____ Cell phone: _____

Employer: _____ Work phone: _____

Primary Insurance: _____

Policy Holder: _____ DOB: ___/___/___ SSN: _____

Relationship: Self, Spouse, Child or Other Employer: _____

Secondary Insurance: _____

Policy Holder: _____ DOB: ___/___/___ SSN: _____

Relationship: Self, Spouse, Child or Other Employer: _____

Consent To Release Information.

I, _____, consent to allowing Dr. James Brillhart to release any information concerning my care, treatment and/or results to the following people. I understand that this consent will be valid until revoked in writing.

FAMILY/FRIENDS

PHYSICIANS

1. _____
2. _____
3. _____
4. _____
5. _____

Primary Care Physician: _____
 Address: _____
 Phone #: _____
 Referring Physician: _____
 Referring Physician #: _____

Consent To Treat Minor

I, _____, the parent or guardian, give Dr Brillhart permission to treat the following minor, _____.

I understand that this consent will be valid until revoked in writing.

