Owen R. Bell, MD, APC
Martha Linden, CNM

Patient Information

Name: _____ S.S.N.: _____

(This information is for identification purposes only and will be kept confidential)

DOB: _____ Age: _____ Driver's License no. State: _____ Marital status: _____

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

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

Preferred pharmacy: _____ Primary Language: _____

Employer: _____ Occupation: _____ Highest grade completed: _____

Race/Ethnicity: ☐ American Indian/Alaska Native ☐ Nat Hawaiian/Pacific Islander ☐ Asian ☐ Hispanic/Latino

☐ White ☐ Black/African American ☐ Other Race: _____ ☐ Decline

Contact Information

Home: _____ Work: _____ Cell: _____ **Best contact: ☐ Home ☐ Work ☐ Cell**

E-mail address: _____ Referred By: _____

Emergency contact: _____ Relationship: _____ Contact no.:_____

Emergency contact: _____ Relationship: _____ Contact no.:_____

Spouse/Partner Information (please circle one)

Name:_____ DOB: _____S.S.N. _____

Employer: _____ Contact Number: _____

Insurance Information (PLEASE FILL OUT, EVEN IF WE HAVE THE CARD)

Insurance co. name: _____ Policy holder: _____ DOB: _____

Do you have ***secondary*** insurance? ☐ **Yes** (enter below) ☐ **No**

Insurance co. name: _____ Policy holder: _____ DOB: _____

To whom may we give laboratory/medical reports?

☐ **Self only** **OR** ☐ Name_____ Relationship_____

May we call you at work to advise you of laboratory/medical reports? ☐ Yes ☐ No

I authorize Dr. Owen Bell to furnish information to insurance carriers concerning my medical records. I assign to Dr. Owen Bell all payments for medical services rendered to me. I understand that I am responsible for any amount not covered by insurance.

I have had the opportunity to review the Notice of Privacy Practices for Owen R. Bell, MD, APC

Signature _____ **Date** _____