Eric C. Nielson, M.D., F.A.C.O.G.
Christopher Barton, M.D.
Kathleen G. Miller, W.H.N.P., C.N.M.
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Julie Frenette, F.N.P., C.N.M.

Mt Olympus Obstetrics & Gynecology

Patient Information

Patient Name (First/Middle/Last)	Date of Birth / /	Age	Marital Status S☐ M☐	Today's Date / /
Address	City		State	Zip Code
Cell Phone ( )	Home Phone ( )			
Social Security #	Email Address			
Name of Employer	Occupation	Work Phone ( )		Extension
Employer Address	City		State	Zip Code
Name of Insured/Responsible Party (First/Middle/Last)	Date of Birth / /	Social Security #	Phone Number ( )	
Name of Employer	Occupation	Work Phone ( )		Extension
In Case of Emergency Contact: Full Name	Relationship	Phone Number ( )		
Primary Physician	Office Name	Office Number ( )		
Who is financially responsible for the bill?	Who can we thank for the referral?			

Permission to Share Limited Health Information

By signing below, I give permission for the person(s) listed to receive limited information about my care. I understand that my healthcare provider will use their professional judgment to ensure that only information pertinent to assisting in my care is released. Any information that does not pertain to assisting with my health care and any copies of my medical records will require a signed HIPAA compliant authorization. This permission will be considered ongoing until I state in writing otherwise. * This is strictly voluntary & you are not required to complete this section*

Full Name of Individual Information May Be Released To	Relationship	Information This Person May Have Access To
		☐ Appointment Scheduling ☐ Pick up Prescriptions ☐ Test Results ☐ Pick up Letters/Forms ☐ Financial/Billing Information ☐ ALL Medical Information
		☐ Appointment Scheduling ☐ Pick up Prescriptions ☐ Test Results ☐ Pick up Letters/Forms ☐ Financial/Billing Information ☐ ALL Medical Information

Is there a phone number where we can leave confidential messages such as test results/special instructions for today's visit as well as for future visits? If yes, phone number:

☐ **DO NOT** release my health information to anyone ☐ **DO NOT** leave any messages on my answering machine

Signature:_____ Date:_____

Relationship to Patient:_____ Witness Signature:_____