Name: _____DOB:_____

CURRENT MEDICATIONS, OVER THE COUNTER MEDICATIONS, VITAMINS and HERBS

PHARMACY NAME AND PHONE NUMBER : _____

Medication	Dosage (Mgs)	Times per day

ALLERGIES and REACTIONS

_____

_____

_____

Do you need a nurse/chaperone present at the time of the Exam?

YES OR NO

LIFETIME INSURANCE AUTHORIZATION

I _____ authorize the release of any medical information necessary to process my insurance claims. I request that all payments be made on my behalf and that all benefits be assigned for physician services to Albany Obstetrics and Gynecology. I authorize this request to apply to all services provided after the date below. I understand I am responsible for payment of any balance not paid by my insurance company, as outlined in my schedule of benefits and as applicable under the law.

_____

Patient Signature. Patient's Name Date