

# ATLANTA GYNECOLOGY & OBSTETRICS, P.C.

- Catherine M. Bonk, M.D. • Kay S. Entrekina, M.D. • Gary A. Glasser, M.D.
- L. Dawn Mandeville, M.D. • Jennifer B. Aqua, M.D. • Jennifer M. Lyman, M.D.
- Lizette S. Persky, RNC, WHNP • Abigail Morgan, RNC, MSN, WHNP • Gretchen Eichenlaub, BSN, MS, WHNP
- Melissa Petersen, RNC, MS, WHNP • Sarah Davis, RNC, MS, WHNP-BC

Date	<b>PATIENT INFORMATION</b>				Patient Number
Last Name	First Name	MI	Date of Birth	Age	
Street Address			Apartment # or Second Address Line		
City	State	ZIP	Email Address		
Home Phone ( )	Work Phone ( )	Extension	Cell Phone ( )	Social Security #	
Race	Religion	Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Separated <input type="checkbox"/> Widowed			
Employment <input type="checkbox"/> Retired <input type="checkbox"/> Full <input type="checkbox"/> Part <input type="checkbox"/> None	Employer/School Name			Job Title	
Student <input type="checkbox"/> Full <input type="checkbox"/> Part	Employer/School Address				
Spouse's Name	Social Security #	Date of Birth	Work Telephone	Job Title	
Spouse's Employer and Address					
<b>INSURANCE INFORMATION</b>					
Primary Insurance Company Name			Insured's Employer		
Name of Insured	Date of Birth	Social Security #	Relationship to Patient		
Group		Policy/ID #			
Secondary Insurance Company Name			Insured's Employer		
Name of Insured	Date of Birth	Social Security #	Relationship to Patient		
Group		Policy			
<b>OTHER INFORMATION</b>					
Please List Any Drug Allergies					
Preferred Pharmacy		Address		Phone Number	
In Case of Emergency Call:		Relationship to Patient	Telephone		
Primary Care Physician		Primary Care Physician's Address		PCP's Telephone	
How did you hear about our practice? <input type="checkbox"/> Friend <input type="checkbox"/> Website <input type="checkbox"/> Yellow Pages					
<input type="checkbox"/> Magazine Ads. Which magazine? _____ <input type="checkbox"/> Other: _____					
<b>Authorization to Release Information</b> I hereby authorize Atlanta Gynecology & Obstetrics, P.C. to release any medical information necessary to process insurance claims and certify that the above information is correct.			<b>Authorization to Pay Benefits</b> I hereby authorize and assign direct payment to Atlanta Gynecology & Obstetrics, P.C. of surgical and medical benefits. I understand that I am financially responsible for charges not covered by this assignment.		
Signed _____ (Insured Person)			Signed _____ (Patient or Responsible person)		