ATLANTA GYNECOLOGY & OBSTETRICS, P.C.

Date	**PATIENT INFORMATION**	Patient Number

Last Name	First Name	MI	Date of Birth	Age

Street Address	Apartment #	Social Security #

City	State	ZIP

Race	Ethnicity	Religion	Language	Marital Status
				☐ Single ☐ Divorced ☐ Partner ☐ Married ☐ Separated ☐ Widowed

Employment ☐ Retired ☐ Full ☐ Part ☐ None Student ☐ Fulltime ☐ Part-Time	Employer/School Name	Job Title

Spouse's Name	Social Security #	Date of Birth	Work Telephone	Job Title

Spouse's Employer	

INSURANCE INFORMATION

Primary Insurance Co. Name	ID#	Insured's Employer	**Group #**

Name of Policyholder	Date of Birth	Social Security #	Relationship to Patient

Secondary Insurance Co. Name	ID#	Insured's Employer	**Group #**

Name of Policyholder	Date of Birth	Social Security #	Relationship to Patient

OTHER INFORMATION

Please List Any Allergies	

Preferred Pharmacy	Phone Number

In Case of Emergency Call:	Relationship to Patient	Telephone

Primary Care Physician	PCP's Telephone

How did you hear about our practice? □ Friend □ Website □ Yellow Pages □ Outside Sign □ Other:_____

Authorization to Release Information

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.

_____

Signed (Patient)

Authorization to Pay Benefits

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 (Patient or Responsible person)

Home: _____ Cell: _____

Work: _____ Email: _____

I authorize Atlanta Gynecology & Obstetrics, P.C. to leave medical information pertaining to my care by the following methods and will assume responsibility to notify them whenever this information changes.

Preferred Point of Contact where messages can be left: **Home** o **Work** o **Cell** o **Email** o

Please list name of the person with whom we can discuss your medical care until revocation by me and completion of a new Patient Information form.

Name: _____ Phone: _____ Relationship: _____

Signature: _____ Date: _____

Patient/Parent/Legal Guardian