

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 <input type="checkbox"/> Single <input type="checkbox"/> Divorced <input type="checkbox"/> Partner <input type="checkbox"/> Married <input type="checkbox"/> Separated <input type="checkbox"/> Widowed	
Preferred Name	Current Gender Identity <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Trans male/Transman/FTM <input type="checkbox"/> Decline to State <input type="checkbox"/> Trans female/Transwoman/MTF <input type="checkbox"/> Different Identity: Please State _____					
Sex Assigned at Birth <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Other	Pronouns <input type="checkbox"/> He/Him/His <input type="checkbox"/> She/Her/Hers <input type="checkbox"/> They/Them/Theirs <input type="checkbox"/> Ze/Zir/Hir <input type="checkbox"/> Otherwise not Listed				Gender on Insurance Plan <input type="checkbox"/> Male <input type="checkbox"/> Female	
Employment <input type="checkbox"/> Retired <input type="checkbox"/> Full <input type="checkbox"/> Part <input type="checkbox"/> None Student: <input type="checkbox"/> Full-time <input type="checkbox"/> 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 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 Work Cell Email

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: _____ (Patient/Parent/Legal Guardian) Date: _____