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Date	PATIENT INFORMATION				Patient Number
Last Name	First Name	MI	Date of Birth	Age	
Street Address		Apt # or Second Address line		Social Security #	
City	State	Zip	Email Address		
Home Phone	Work Phone	Ext.	Cell Phone	Preferred Daytime Phone <input type="checkbox"/> Home <input type="checkbox"/> Work <input type="checkbox"/> Cell	
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 Phone	Job Title	
Spouse's Employer and Address					
INSURANCE INFORMATION					
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/ID #			
OTHER INFORMATION					
Referred to our practice by					
Preferred Pharmacy Name	Pharmacy Address			Pharmacy Phone	
Name of Emergency Contact		Relationship to Patient		Phone	
Primary Care Physician	Primary Care Physician's Address		Primary Care Physician's Phone		
Authorization to Release Information I hereby authorize Gynecology & Obstetrics of DeKalb, P.C. to release any medical information necessary to process insurance claims and certify that the above information is correct. _____ Sign (Insured Person)			Authorization to Pay Benefits I hereby authorize and assign direct payment to Gynecology & Obstetrics of DeKalb, P.C. of surgical and medical benefits. I understand that I am financially responsible for charges not covered by this assignment. _____ Sign (Insured Person)		

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