Christian D. Geltz, D.O. ● John L. Carter, Jr., M.D. ● Pamela Jo Brown, M.D. ● William L. Hutchinson, Jr., M.D.

Genesis A. Bowen, M.D. ● Amy Rodatus, MD.

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 ☐ Home ☐ Work ☐ Cell

Race	Religion	Marital Status ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed

Employment ☐ Retired ☐ Full ☐ Part ☐ None	Employer/School Name	Job Title

Student ☐ Full ☐ 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.

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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.

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Sign (Insured Person)

FINANCIAL AGREEMENT: ***OUR OFFICE DOES NOT BILL PATIENTS FOR OFFICE VISITS OR COPAYS. PAYMENTS MUST BE MADE AT THE TIME OF VISIT.***

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Sign