

Gynecology and Obstetrics of DeKalb, P.C.

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|---|----------------------------|--|--|-------------------------|---|
| Date | PATIENT INFORMATION | | | Account 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 | | | | | |
| INSURANCE INFORMATION | | | | | |
| Primary Insurance Company Name | | | Group | Policy/ID # | |
| Address To Mail Claims | | | | Insured's Employer | |
| Name of Insured | | Date of Birth | Social Security # | Relationship to Patient | |
| Secondary Insurance Company Name | | | Group | Policy | |
| Address To Mail Claims | | | | Insured's Employer | |
| Name of Insured | | Date of Birth | Social Security # | Relationship to Patient | |
| OTHER INFORMATION | | | | | |
| Please list any Drug Allergies | | | | | |
| In Case of Emergency Call: | | Relationship to Patient | Telephone | | |
| Referred to our Practice by | | | | | |
| Primary Care Physician | | Primary Care Physician's Address | | | PCP's Telephone |
| Authorization to Release Information I hereby authorize Gynecology and Obstetrics of DeKalb, P.C. to release any medical information necessary to process insurance claims and certify that the above information is correct. | | | Authorization to Pay Benefits I hereby authorize and assign direct payment to Gynecology and Obstetrics of DeKalb, 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) | | |

Financial Agreement: Our office does not bill patients for office visits or copays. Payments must be made at time of visit. Signature: _____

Privacy Practices: I have received a copy of Gynecology and Obstetrics of DeKalb, P.C.. Signature: _____