Atlanta Women's Specialists

Patient Demographics Information

Patient Information

Name___________________________________
(Last) (First) (Middle)

Home Address______________________________

City________________ State ________ Zip_______

Home Phone ________________________________

Work Phone _____________Cell________________

Date of Birth_____________________ Age _______

Social Security Number _______________________

Occupation _________________________________

Employer___________________________________

Address ____________________________________

City__________________ State________ Zip______

E-mail ______________________________________

Spouse/Parent/Guardian Information

Name_______________________________________

Social Security Number _______________________

Occupation/Employer_________________________

Health Insurance Information

Insurance Co:______________________________

Address_____________________________________

City________________ State________Zip_______

Policy # __________________________________

Group # __________________________________

Policy Holder's Name________________________

Policy Holder's Date of Birth _________________

Secondary Insurance

Insured's Name ____________________________

Address_____________________________________

City ____

State______________________ Zip_____________

Work Phone Number ________________________

Policy # ___________________________________

Policy Holder's Name ________________________

Policy Holder's Date of Birth___________________

I was referred by: (circle all that apply) Friend Physician Yellow pages Provider Directory

Emergency Contact

Name:____ Phone Number_____________________________

<u>Patient-Physician Agreement</u>

Payment for office services is due on the day of the visit. Payment may be made by check, charge or cash. An itemized copy of the services provided is available to you for insurance purposes. Insurance and financial arrangements should be made with our business office prior to surgery and obstetrical care.

Laboratory and pathology services are provided and billed to you by a third-party.

I recognize that the medical insurance I possess may not completely cover the fee(s) for professional services rendered to me. I hereby agree that I am responsible for said fee(s). I authorize payment directly to and assign to the Atlanta Women's Specialists the surgical/medical benefits, if any, otherwise payable to me for their services. I hereby state all information provided is true and complete to the best of my knowledge. I agree that I will be responsible for all collection fees incurred if an outside collection agency is used to recover past due balances.

I acknowledge and understand the payment policies of Atlanta Women's Specialists.

X____ Date______________________

I authorize release of medical information necessary to process claims made by Atlanta Women's Specialists for services rendered to me. I also certify that the information contained here in complete.

X____ Date______________________

I acknowledge that I have reviewed ATLANTA WOMEN'S SPECIALISTS's **Notice of Privacy Practices.**

X____Date______________________