GWINNETT OB/GYN ASSOCIATES, P.C.

Today's Date: _____ Chart #: _____

PATIENT INFORMATION (please print – blue or black ink only)

Name: _____ Age:_____ Birth Date: _____
Last First MI

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____ E-Mail Address: _____

Social Security Number: _____ Primary Care Physician: _____

Employed? (circle one) Yes No **Full-time Student?** (circle one) Yes No

Employer: _____ Work Phone: _____ Occupation: _____

Work Address: _____ City: _____ State: _____ Zip:_____

Marital Status (circle one) Single Married Divorced Widowed **Who referred you here?** _____

SPOUSE INFORMATION

Name: _____ Social Security Number: _____ Birth Date: _____

Employer: _____ Work Phone: _____ Cell Phone: _____

Work Address: _____ City: _____ State: _____ Zip: _____

PERSON TO NOTIFY IN CASE OF EMERGENCY

Name: _____ Relationship: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

INSURANCE INFORMATION

Primary Insurance Co. Name: _____ Group #: _____ ID# _____

Address: _____ City: _____ State: _____ Zip: _____

Policy Holder's Name: _____ Social Security Number: _____

Date of Birth: _____ Relation to Patient (circle one) Self Spouse Mother Father Other

Secondary Insurance Co. Name: _____ Group #: _____ ID#: _____

Address: _____ City: _____ State: _____ Zip: _____

Policy Holder's Name: _____ Social Security Number: _____

Date of Birth: _____ Relation to Patient (circle one) Self Spouse Mother Father Other

I authorize the release of any medical information necessary to process insurance claims. My signature also authorizes payment of medical benefits to the named provider for professional services rendered. I understand that I am financially responsible for all services rendered, that there is a $30 returned check fee and that 30% will be added to my balance if my account must be referred to an agency for collection. Additionally, I understand that if I am covered by an insurance that requires a referral number, <u>it is my responsibility to obtain that referral number prior to my visit.</u>

_____ _____
(Patient's Signature) (Date)