PATIENT INFORMATION (Please print)

Last Name First Name Middle Name Social Security Number

Home Address City State Zip

( ) ( ) ( )
Home Phone Number Work Phone Number Cell Phone Number Email Address

/ /
Date of Birth Marital Status ( ) Pharmacy Number

Employer/ Occupation

Employer Address City State Zip

Individual to Contact in an Emergency Relationship

( ) ( ) ( )
Home Phone Number Work Phone Number Cell Phone Number

How did you hear about this practice? _____

☐ Google ☐ CallaDoctor.net ☐ ZocDoc ☐ Yellow Pages ☐ Insurance Web site ☐ Kudzo

☐ Friend/ Family _____ ☐ Physician Referral _____

PRIMARY CARD HOLDER INFORMATION/GUARANTOR INFORMAITON (If self skip this section)

Last Name Middle Name First Name Relationship to Patient

Home Address City State Zip

( ) ( ) / /
Home Phone Number Work Phone Number Date of Birth Social Security Number

Employer Address City State Zip

Assignment of Benefit/Consent for Treatment: I do hereby assign all medical and/or surgical benefits to which I am entitled, including all government and private insurance plans to Georgia Gynecology, P.C. office. This assignment will remain in effect until revoked by me in writing. I understand that I am responsible for all my charges not paid by my insurance. I understand that I am responsible for all applicable interest or service charges, and/or collection costs associated with collecting the debt, including reasonable attorney's fees due to default in payment. I hereby voluntarily consent to my treatment at Georgia Gynecology, P.C. office and authorize such treatments, examinations, medications, anesthesia, surgical operations and diagnostic procedures (including, but not limited to the use of lab and radiographic studies) as ordered by my attending physicians. I have read this consent, am aware of its contents and fully understand the same. I acknowledge that no assurance or promises have been given to the patient concerning the results, which may be obtained by such treatments and procedures hereby, affirmed by the signature of the undersigned.

PATIENT SIGNATURE_____**DATE**_____

GUARDIAN SIGNATURE_____**DATE**_____