Atlanta Perinatal Associates

Thank you for choosing **Atlanta Perinatal Associates.** In order to serve you, we will need the following information. All Information is strictly confidential.

DATE:_____ OFFICE: _____ PRIMARY LANGUAGE SPOKEN:_____

PATIENT NAME:_____
(Last) (First) (Middle)

CHECK ONE: SEX: M_____ F_____ CHECK ONE: MARRIED_____ SINGLE_____ WIDOWED_____ DIVORCED_____

RACE: _____ ETHNICITY: _____ ADVANCED DIRECTIVES: YES ____ NO ____

DATE OF BIRTH: _____ SOCIAL SECURITY #:_____

RESPONSIBLE PARTY:_____RELATIONSHIP:_____ PHONE #:_____

PATIENT'S LOCAL ADDRESS:_____
(Street) (City) (Zip)

PERMANENT ADDRESS (IF DIFFERENT): _____

HOME TELEPHONE #: (_____) _____ CELL #: (____) _____ EMAIL:_____

EMPLOYED BY: _____ OCCUPATION:_____ WORK # (____) _____

BUSINESS ADDRESS: _____

EMERGENCY CONTACT:_____ RELATIONSHIP:_____ PHONE #: (____)_____

ALLERGIES TO MEDICATIONS:_____

PRIMARY PHARMACY: _____ PHONE #: (____)_____ LOCATION: _____

PRIMARY CARE PHYSICIAN: _____

REFERRED BY:_____ REASON FOR VISIT: _____

CHECK ONE: ILLNESS/INJURY RELATED TO: WORK ____ AUTO ____ OTHER ____ DATE OF INCIDENT: _____

INSURANCE INFORMATION

NAME OF **PRIMARY INSURANCE** COMPANY:_____ HMO_____ PPO _____ POS _____
(If applies, check)

POLICY/ID#_____ GROUP #_____

POLICY HOLDER:_____ RELATIONSHIP:_____

POLICY HOLDER'S DATE OF BIRTH:_____ SOCIAL SECURITY #:_____

NAME OF **SECONDARY INSURANCE** COMPANY:_____ HMO_____ PPO _____ POS _____
(If applies, check)

POLICY/ ID#_____ GROUP #_____

POLICY HOLDER:_____ RELATIONSHIP:_____

POLICY HOLDER'S DATE OF BIRTH:_____ SOCIAL SECURITY #:_____

Authorization and Consent To Bill and Pay Benefits to Atlanta Perinatal Associates

I hereby assign payment directly to **Atlanta Perinatal Associates**, for any medical/surgical procedures performed. I agree that this authorization shall be valid until rescinded in writing or replaced by one of a later date. I agree to be financially responsible to **Atlanta Perinatal Associates** for all charges in the event that I have no insurance or my insurance is rejected, and for any balance or fee not covered by my insurance and/or determined to be my responsibility. I understand and acknowledge that if to **Atlanta Perinatal Associates** files my insurance claim, I will remain responsible for the account, and I will be expected to pay any amount due if my insurance does not pay the claim. This office will file insurance claims as a courtesy to the patient. However, payment in full is expected when services are rendered. It is further understood that verification of insurance benefits is not a guarantee of payment by the carrier. I hereby authorize **Atlanta Perinatal Associates** and/or its staff to release medical information to insurance companies concerning the patients illness and treatment.

General Consent to Treatment

By signing below, I (or my authorized representative on my behalf) authorize **APA** physicians, practitioners and their staff to conduct any diagnostic examinations, tests and procedures and to provide any medications, treatment or therapy necessary to effectively assess and maintain my health, and to assess, diagnose and treat my illness or injuries. I understand that it is the responsibility of my individual treating healthcare providers to explain to me the reasons for any particular diagnostic examination, test or procedure, the available treatment options and the common risks and anticipated burdens and benefits associated with these options as well as alternative courses of treatment.

Signature_____ Date_____ **Staff Initial**____