GEORGIA PERINATAL CONSULTANTS

Name _____ Soc Sec # _____
(First Name) (Middle) (Last Name) (Preferred Name)

Address _____ Home Phone (_____) _____

City _____ State _____ Zip Code _____ Cell Phone (_____) _____

Birthdate _____ Age _____ Race _____ Business Phone _____

Email Address _____ ☐ Single ☐ Married ☐ Other

Patient Employer _____ Occupation _____

Please check [√] the **preferred** contact number for us to call regarding lab results or appointments: ☐Home ☐Work ☐ Other
May we leave a voicemail or message at this number: ☐ Yes ☐ No

Referring Physician / Midwife _____ **Office Phone** _____

Spouse/Partner Name _____ Soc Sec # _____
(First Name) (Middle) (Last Name)

Address _____ Home Phone (_____) _____

City _____ State _____ Zip Code _____ Birthdate _____ Age _____ Race _____

Employer _____ Occupation _____

Primary Insurance Carrier _____

Policy Subscriber Name _____ Relationship to Patient ☐*Spouse/Partner* ☐*Child* ☐*Dependent*

Policy # _____ Group # _____

Secondary Insurance Carrier _____

Policy Subscriber Name _____ Relationship to Patient ☐*Spouse/Partner* ☐*Child* ☐*Dependent*

Policy # _____ Group # _____

Please list by name any person (i.e., spouse, relative) authorized by you to speak with our staff on your behalf regarding your medical care, lab results, clinical findings, etc. _____, as authorized by your signature below.

In the event that it becomes necessary to refer me to another physician/facility, or I am given any portion of my medical record to take with me, my signature below authorizes the release of information by Georgia Perinatal Consultants for these purposes. _____
(Initials)

I, the undersigned, have reviewed an electronic copy and/or received a paper copy of Georgia Perinatal Consultants, LLP's Notice of Privacy Practices. _____
(Initials)

I, the undersigned certify that I (or my dependent) have insurance coverage with _____, and assign directly to Georgia Perinatal Consultants all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. Additionally, it is my responsibility to inform Georgia Perinatal Consultants of insurance changes at the time of visit, and failure to do so may result in the visit being my financial liability. If my account is delinquent, collection fees may become my responsibility, potentially increasing the balance due. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

_____ _____
Patient Signature Date