MACON GYN OB ASSOCIATES, P.A.

PATIENT INFORMATION PLEASE PRINT ALL INFORMATION			***CHECK PREFERRED WAY TO CONTACT YOU BELOW***	
NAME (LAST, FIRST, M.I.)	BIRTH DATE	SSN:	HOME PHONE	
STREET ADDRESS:	CITY, STATE & ZIP		CELL PHONE	
MAILING ADDRESS (IF DIFFERENT)	CITY, STATE & ZIP		WORK PHONE	
EMPLOYER:	ADDRESS		PRIMARY CARE PHYSICIAN	
PRIMARY INSURANCE (NAME ONLY)	SECONDARY INSURANCE (NAME ONLY)		REFERRING PHYSICIAN	
RACE(PLEASE CIRCLE ONE) WHITE, BLACK OR AFRICAN AMERICAN, BIRACIAL, AMERICAN INDIAN, ASIAN, NATIVE HAWAIIAN OR OTHER PACIFIC ISLAND, HISPANIC, OTHER IF YOU PREFER NOT TO ANSWER, CHECK HERE:_____	**ETHNICITY (PLEASE CIRCLE ONE): NON-HISPANIC OR HISPANIC** **IF YOU WOULD PREFER NOT TO ANSWER, CHECK HERE:____**			
SPOUSE INFORMATION	TO RECEIVE TEST RESULTS BY E-MAIL, LIST E-MAIL ADDRESS:			
NAME (LAST, FIRST, M.I.)	BIRTH DATE:	SSN:	**MARITAL STATUS: S M D W SEPERATED**	
EMPLOYER:	ADDRESS	WORK PHONE:		

MUST BE COMPLETED IF UNDER AGE 18 (OR UNDER 26 IF ON PARENTS INS)

FATHER:			
NAME	**ADDRESS**	**BIRTH DATE**	**SSN:**
EMPLOYER NAME	***ADDRESS***	***WORK PHONE:***	

MOTHER:			
NAME	***ADDRESS***	***BIRTH DATE***	***SSN:***
EMPLOYER NAME	**ADDRESS**	**WORK PHONE**	

AUTHORIZATIONS

***** PLEASE PRESENT CO-PAY ALONG WITH INSURANCE CARDS AND PICTURE I.D. TO THE RECEPTIONIST *****

IF YOU ARE A SELF PAY PATIENT, ALL PAYMENTS ARE DUE AT THE TIME SERVICES ARE

INSURANCE AUTHORIZATION AND ASSIGNMENT

1. **RELEASE OF MEDICAL RECORDS**: I HEREBY AUTHORIZE MACON GYN-OB ASSOCIATES, P.A. TO FURNISH MEDICAL INFORMATION TO MY INSURANCE CARRIER(S) CONCERNING MY ILLNESS, TREATMENTS, PAYMENTS AND HEALTHCARE OPERATIONS.
2. **ASSIGNMENT BENEFITS**: I HEREBY ASSIGN TO THE PHYSICIAN(S) ALL PAYMENTS FOR MEDICAL SERVICES RENDERED TO MYSELF OR MY DEPENDENTS. I UNDERSTAND THAT I AM RESPONSIBLE FOR ANY AMOUNT NOT COVERED BY INSURANCE.
3. **INFORMATION RELEASE**: I AUTHORIZE THE RELEASE OF ANY MEDICAL INFORMATION NECESSARY TO PROCESS CLAIMS.

I HAVE READ AND FULLY UNDERSTAND THE ABOVE CONSENT FOR TREATMENT, RELEASE OF MEDICAL INFORMATION, FINANCIAL RESPONSIBILITY AND INSURANCE AUTHORIZATION.

DATE: SIGNATURE: