ALPHA OB GYN

2905 Jordan Ct, Suite G, Alpharetta, GA 30005 P: (678)335-9223 F: (678)335-9236

Patient Information

Date_____

Last Name_____First_____Middle_____

Preferred Name _____ Maiden Name_____

Social Security #_____ Date of Birth_____

Race_____ Religion_____ Language_____ Marital Status: □ Single □Married □Divorced □Widowed

Address _____ City _____ State_____ Zip_____

Home Phone _____ Cell Phone_____ Office Phone_____

Email Address_____ Contact Preference _____

Employer _____

Spouse's Last Name_____ First_____ Middle_____

Spouse's Date of Birth _____ Spouse's Cell Phone _____

Pharmacy Name_____ Phone _____

Pharmacy Address_____ City_____ Zip_____

Primary Care Physician_____ Phone _____

Primary Care Physician's Practice Name _____

Primary Care Physician's Address_____ City_____ Zip_____

How did you hear about our Practice? _____

Authorization to Treat Minor:

Last Name_____ First_____ DOB_____

□ Parent □ Guardian □ Other _____ Phone_____

Signature _____ Date _____

Insurance Information

Primary Insurance _____

Policy #_____ Group #_____

Policy Holder Name _____ Relationship to You □ Self □ Spouse □ Parent

Policy Holder Birthdate_____ Policy Holder Social Security #_____

Secondary Insurance _____

Policy # _____ Group #_____

Policy Holder Name_____ Relationship to You □ Self □ Spouse □ Parent

Please give you insurance cards to the receptionist so we may keep a copy on file

I authorize Alpha OB/GYN to furnish all information required to insurance carriers and other health care providers regarding my illness and treatment. I assign to Alpha OB/GYN all payments for medical services rendered to myself or my dependents. I understand that I am responsible for any amount not covered by insurance. This information includes Protected Health Information.

Signature _____ **Date** _____