

**MACON GYN OB ASSOCIATES, P.A.**

<b>PATIENT INFORMATION</b>			<b>PLEASE PRINT ALL INFORMATION</b>		<b>CHECK PREFERRED WAY TO CONTACT YOU BELOW</b>
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:	EMAIL ADDRESS:		PRIMARY CARE PHYSICIAN		
PRIMARY INSURANCE (NAME ONLY)	SECONDARY INSURANCE (NAME ONLY)		REFERRING PHYSICIAN		
<b>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: _____</b>			<b>ETHNICITY (PLEASE CIRCLE ONE): NON-HISPANIC OR HISPANIC IF YOU WOULD PREFER NOT TO ANSWER, CHECK HERE</b>		
<b>SPOUSE INFORMATION:</b>			<b>MARITAL STATUS: S M D W SEPERATED</b>		
NAME (LAST, FIRST, M.I.)	BIRTH DATE:	SSN:			
EMPLOYER:	ADDRESS		WORK PHONE:		
<b>MUST BE COMPLETED IF UNDER AGE 18 (OR UNDER 26 IF ON PARENTS INS)</b>					
<b>FATHER:</b>					
NAME	ADDRESS		BIRTH DATE	SSN:	
<i>EMPLOYER NAME</i>	<i>ADDRESS</i>		<i>WORK PHONE:</i>		
<b>MOTHER:</b>					
NAME	ADDRESS		BIRTH DATE	SSN:	
EMPLOYER NAME	ADDRESS		WORK PHONE		
<b>AUTHORIZATIONS</b>					

**\*\* 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: