Dr. McSwain

Dr. Ingvoldstad

Dr. Dozier

Dr. Roberts

Dr. Knoer

Peachtree Women's Specialists

Today's date _____ Referred by _____

Please print and fill out completely. Account #_____

Legal **Name** _____ Date of birth _____

Name we should use (Nickname) _____ S.S # _____

Home address _____ Apt # _____

City _____ State _____ Zip code _____ Home phone _____

Occupation _____ Cell phone _____

Employed by _____ Work phone _____

SPOUSE's name _____ Marital status S M D W Your email _____

Spouse's occupation _____ Employer _____ Work phone _____

Person with whom we may leave results (name / relation) _____

Emergency contact's name, rel, phone (not living with you) _____

Primary care physician _____ PCP's phone _____

Referring physician _____ Ref phys phone _____

If **MINOR**, responsible adult / relationship _____

Address _____ City, state, zip _____ Phone _____

Occupation _____ Employer _____

Primary Insurance Ins Name _____ Effective Date _____ Phone _____

Policy holder's name _____ Date of birth _____

ID # _____ Group number _____

Type of plan (circle one) HMO POS PPO EPO Indemnity Commercial

Secondary Insurance Ins Name _____ Effective date _____ Phone _____

Policy holder's name _____ Date of birth _____

ID # _____ Group number _____

Type of plan (circle one) HMO POS PPO EPO Indemnity Commercial

Authorization for Treatment:

I consent to examination, treatment and procedures, which may be performed during office visits including emergency treatment considered necessary by the physician and / or his designated provider.

Assignment of Insurance Benefits:

I hereby assign payment directly to Peachtree Women's Specialists for services covered by insurance or other health benefit plans.

Authorization for Release of Information:

I authorize Peachtree Women's Specialists to release to my insurance carrier and its designated agents any medical information, including information related to psychiatric care, drug or alcohol abuse, and HIV / AIDS, necessary to process any healthcare related utilization review or quality assurance activities. I further authorize the release of any medical information to other healthcare providers to whom or from whom I have been referred for healthcare services or who provide consultative services regarding my medical care. This authorization shall remain in effect until revoked by me in writing. I know that I have a right to receive a copy of this authorization upon request and agree that a photocopy of same is as valid as the original.

SIGNATURE OF PATIENT OR GUARDIAN: _____ **Date** _____