

Gracias por elegir a **Atlanta Perinatal Associates**. Para servirle, vamos a necesitar lo siguiente. Toda la información es estrictamente confidencial.

FECHA: _____ OFICINA: _____ PRIMER IDIOMA: _____

NOMBRE: _____
(Apellido) (Primer Nombre) (Segundo Nombre)

MARQUE UNO: SEXO: M _____ F _____ MARQUE UNO: CASADA _____ SOLTERA _____ VIUDA _____ DIVORCIADA _____

RAZA: _____ ETNICIDAD: _____ DIRECTIVAS AVANZADAS: SI _____ NO _____

FECHA DE NACIMIENTO: _____ SEGURO SOCIAL #: _____

RESPONSIBLE PARTY: _____ RELATIONSHIP: _____ PHONE #: _____

DIRECCION DE CASA: _____
(CALLE) (CIUDAD) (CODIGO POSTAL)

PERMANENT ADDRESS (SI ES DIFERENTE): _____

TELEFONO DE CASA#: (____) _____ TELEFONO MOVIL #: (____) _____

CORREO ELECTRONICO: _____

NOMBRE DE EMPLEO: _____ OCUPACION: _____ TRABAJO# (____) _____

DIRECCION DE SU TRABAJO: _____

CONTACTO DE EMERGENCIA: _____ RELACION: _____ # DE TELEFONO: (____) _____

ALGUNA ALERGICA A UN MEDICAMENTO?: _____

NOMBRE DE SU FARMACIA: _____ TELEFONO#: (____) _____ DIRECCION: _____

NOMBRE DEL SU DOCTOR PRIMARIO: _____

DOCTOR QUE LA REFIRIO: _____ RAZON POR SU VISITA: _____

MARQUE UNO: ENFERMEDAD/LESIONES RELACIONADAS: TRABAJO _____ CARRO _____ OTRO _____ FECHA DEL INCIDENTE: _____

INFORMACION DE SU SEGURO

NOMBRE DE **SEGURO PRIMARIO**: _____ HMO _____ PPO _____ POS _____
(marque uno si aplica)

#DE POLISA _____ # GRUPO _____

POSEEDOR DE POLISA: _____ RELACION: _____

FECHA DE NACIMIENTO DEL POSEEDOR DE POLISA: _____ SEGURO SOCIAL #: _____

NOMBRE DEL **SEGURO SEGUNDO**: _____ HMO _____ PPO _____ POS _____
(marque uno si aplica)

#DE POLISA _____ GRUPO# _____

POSEEDOR DE POLISA: _____ RELACION: _____

FECHA DE NACIMIENTO DEL POSEEDOR DE POLISA: _____ SEGURO SOCIAL #: _____

Authorization and Consent to Bill and Pay Benefits to PageMed, LLC

I hereby assign payment directly to **PageMed, LLC**, for any medical/surgical procedures performed. I agree that this authorization shall be valid until rescinded in writing or replaced by one of a later date. I agree to be financially responsible to **PageMed, LLC** for all charges in the event that I have no insurance or my insurance is rejected, and for any balance or fee not covered by my insurance and/or determined to be my responsibility. I understand and acknowledge that if to **PageMed, LLC** files my insurance claim, I will remain responsible for the account, and I will be expected to pay any amount due if my insurance does not pay the claim. This office will file insurance claims as a courtesy to the patient. However, payment in full is expected when services are rendered. It is further understood that verification of insurance benefits is not a guarantee of payment by the carrier. I hereby authorize **PageMed, LLC** and/or its staff to release medical information to insurance companies concerning the patients illness and treatment.

General Consent to Treatment

By signing below, I (or my authorized representative on my behalf) authorize **PageMed, LLC** physicians, practitioners and their staff to conduct any diagnostic examinations, tests and procedures and to provide any medications, treatment or therapy necessary to effectively assess and maintain my health, and to assess, diagnose and treat my illness or injuries. I understand that it is the responsibility of my individual treating healthcare providers to explain to me the reasons for any particular diagnostic examination, test or procedure, the available treatment options and the common risks and anticipated burdens and benefits associated with these options as well as alternative courses of treatment.

Signature _____ Date _____ Staff Initial _____