

Georgia Center for Female Health, LLC

Lynette D. Stewart, MD

Beverly Pottinger-Pickens, DO

PATIENT INFORMATION (PLEASE Print)			
Last Name/APELLIDO	First Name/Nombre	Initial	Date of Birth/Fecha de Nacimiento
Address/Direccion	City/Cuidad	State/Estado	Zipcode/CodigoPostal
Social Security Number	Sex/Sexo <input type="checkbox"/> F <input type="checkbox"/> M	Marital Status/Estado Civil <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Separated <input type="checkbox"/> widow	
Home Phone Number* Required*	Cell Phone number/Numero de Cellular	Email Address/Correo Electronico	
Employer/Empleador del Paciente	Employer Address (Direccion de Empleador)	Work Phone/ Telefono de trabajo	
Spouse's Name/Nombre del Esposo	Date of birth/Fecha de Nacimiento	Social Security Number	
Spouse's employer & address/Nombre y Direccion de trabajo		Spouse's work number/Telefono de trabajo del Esposo	
In case of an Emergency please list the nearest relative (Not residing at the Same address as yours)			
En caso de Emergencia por favor ponga el nombre del pariente mas cercano			
Name/Nombre	Telephone Number/Numero de Telefono	Relationship to patient/ Relacion al paciente	
Address/Direccion	City/Cuidad	State/Estado	ZipCode/CodigoPostal

Insurance Information/Informacion de Seguro

Primary Insurance carrier/Nombre del Seguro	Subscriber (<i>If not the Patient</i>)/Subsribidor		
Policy Number (Usually SSN#)Numero de Poliza	Group Number/Numero de Grupo	Relationship to Patient/Relacion al paciente <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other	
Secondary Insurance carrier/Seguro Secundario	Subscriber/Subsribidor		
Policy Number (Usually SSN#)Numero de Poliza	Group Number/Numero de Grupo	Relationship to patient/Relacion al paciente	
<i>How did you hear about us?</i> <input type="checkbox"/> Insurance Directory <input type="checkbox"/> Direct Mail <input type="checkbox"/> Telephone directory <input type="checkbox"/> Radio			
Friend's Name:		Physician:	

I consent to treatment necessary for the care of the above named patient.

Authorization to release information, I hereby authorize this practice to furnish any medical information requested by insurance companies with whom I have coverage, or any public agency which may be assisting with payment of my care.

Assignment or Insurance Benefits-I hereby authorize payment directly to this practice of benefits otherwise payable to me, including major medical insurance, and payment or surgical and medical benefits, not to exceed the charges of the service. I understand that I am financially responsible for charges not covered by this assignment or by my insurance.

Guarantor or Account for services furnished and provided by the Physicians at *Georgia Center for Female Health*, I authorize payment of all accounts for services rendered to me. For payment of said accounts for services which I hereby waive all claims of exemption under the laws of the State of Georgia, and agree to pay If necessary all cost of collection handling, legal, and/or attorney's fee. *Financial Policy* I have read and acknowledged the financial policy of this practice and agree to its terms and conditions.

Signature

Date

Primary Office: <input type="checkbox"/> Norcross <input type="checkbox"/> Decatur	Patient Type <input type="checkbox"/> OB <input type="checkbox"/> GYN
Primary Physician: <input type="checkbox"/> Lynette Stewart, MD <input type="checkbox"/> Beverly Pottinger-Pickens, DO	
Services Not covered by Plan:	<input type="checkbox"/> DEPO by Rx Only