



# Peachtree City Obstetrics & Gynecology, P.C.

Rebecca Banks, MD, FACOG, Mironda Williams, MD, FACOG,  
Deanna Guthrie, MD, FACOG, Karen Greene, MD, FACOG

## PATIENT INFORMATION UPDATE

Date: \_\_\_\_\_ (Please Print) Acct. #: \_\_\_\_\_

Name \_\_\_\_\_ I prefer to be called \_\_\_\_\_

Social Security Number \_\_\_\_\_ Drivers License Number \_\_\_\_\_

Home Address \_\_\_\_\_ Apt# \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Phone #1) \_\_\_\_\_ # 2) \_\_\_\_\_ Work# \_\_\_\_\_

Birthdate \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ Age \_\_\_\_\_ \* Marital Status \_\_\_\_\_

\*Employed by \_\_\_\_\_ Occupation \_\_\_\_\_

Work Address \_\_\_\_\_ F/T \_\_\_\_\_ P/T \_\_\_\_\_

Spouse/Parent \_\_\_\_\_ H. Phone \_\_\_\_\_ W. Phone \_\_\_\_\_

Employed by \_\_\_\_\_ Occupation \_\_\_\_\_

Full Time Student \_\_\_\_\_ Part Time Student \_\_\_\_\_ N/A \_\_\_\_\_

## INSURANCE INFORMATION UPDATE

**Primary** Insurance Co. \_\_\_\_\_

\*Subscriber's Name \_\_\_\_\_ Subscriber's Employer \_\_\_\_\_

Work Address \_\_\_\_\_ Work Phone # \_\_\_\_\_

Subscriber's Social Security No. \_\_\_\_\_ \* Subscriber's Birthdate \_\_\_\_\_

\*Patient's Relationship to Subscriber \_\_\_\_\_

Subscriber's Address if different from Patient's \_\_\_\_\_

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**Secondary** Insurance Co. \_\_\_\_\_

Subscriber's Name \_\_\_\_\_ Subscriber's Employer \_\_\_\_\_

Work Address \_\_\_\_\_ Work Phone # \_\_\_\_\_

Subscriber's Social Security No. \_\_\_\_\_ \* Subscriber's Birthdate \_\_\_\_\_

\*Patient's Relationship to Subscriber \_\_\_\_\_

Subscriber's Address if different from Patient's \_\_\_\_\_



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## **CORRECT INSURANCE INFORMATION MUST BE PRESENTED AT EACH VISIT**

### **AUTHORIZATION AND RELEASE**

PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE: I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment.

SIGNED: \_\_\_\_\_ DATE: \_\_\_\_\_

INSURED'S OR AUTHORIZED PERSON'S SIGNATURE: I authorize payment of medical benefits to *Peachtree City Obstetrics and Gynecology, P.C.* for stated medical services.

SIGNED: \_\_\_\_\_ DATE: \_\_\_\_\_

**I UNDERSTAND THAT I AM RESPONSIBLE FOR ANY AMOUNT NOT COVERED BY INSURANCE.**

SIGNED: \_\_\_\_\_ DATE: \_\_\_\_\_

**Payment is required at the time services are rendered.  
A \$25.00 fee will be charged for checks returned for nonsufficient funds.**