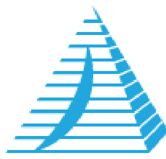

Atlanta Perinatal Associates

Gracias por elegir a **Atlanta Perinatal Associates.** Para servirle , vamosa necesitar lo siguiente. Toda la informacion 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 #:______________________

DIRENCCION DE CASA:____

(CALLE) (CIUDAD) (CODIGO POSTAL)

PERMANENT ADDRESS (SI ES DIFERENTE): ____

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

CORREO ELECTRONICO:__________________________

NOMBRE DE EMPLEO : _______________________ OCUPASION:____________________ 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 RELASIONADAS :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 Atlanta Perinatal Associates

I hereby assign payment directly to **Atlanta Perinatal Associates**, 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 **Atlanta Perinatal Associates** 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 **Atlanta Perinatal Associates** 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 **Atlanta Perinatal Associates** 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 **APA** 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**______