PATIENT INFORMATION

TODAY'S DATE: _____ / _____ / _____ **REFERRING PHYSICIAN:** [ ]

OB/GYN PHYSICIAN: [ ] **PRIMARY CARE PHYSICIAN:** [ ]

PATIENT INFORMATION

LAST NAME: ______________________________ **FIRST NAME:** ____________________________________ **MI:** ______ **DOB:** _____/______/_______

ADDRESS: ________________________________ **CITY:** ____ **STATE:** _____ **ZIP :** ______________________

CELL #: ( ) ______________________________ **HOME #:** ( ) _________________________ **WORK #:** ( ) _______________________

May we leave a message on these contact numbers? yes no **EMAIL ADDRESS:** ____

LANGUAGE: English Spanish Other: _______________________ **ETHNICITY:** Hispanic/Latin Not Hispanic/Latin Decline to specify

RACE: African-American Asian Hispanic Native American White Other: ____

GENDER: Male Female Transgender Male Transgender Female Decline to answer **SEX ASSIGNED AT BIRTH:** Male Female

PRONOUNS THAT YOU PREFER WHEN TALKING WITH YOU: She/her/hers He/him/his They/them/theirs Other - Please specify: __________

MARITAL STATUS: Single Married Widowed Divorced Legally Separated

LAST 4 DIGITS OF YOUR SOCIAL SECURITY #: ______ ______ ______ ______

EMPLOYER NAME: ____

INSURANCE INFORMATION

INSURANCE CARRIER: __________________________________

SPECIALIST CO-PAYMENT AMT: ________

POLICY HOLDER NAME: __________________________________ **DATE OF BIRTH:** ____/____/______

RELATIONSHIP TO INSURED: Self Spouse Child Other: ____

IN CASE OF EMERGENCY

NAME OF CONTACT: ____________________________________ **RELATIONSHIP TO PATIENT:** ________________ **PHONE #:** _________________

NAME OF CONTACT: ____________________________________ **RELATIONSHIP TO PATIENT:** ________________ **PHONE #:** _________________

PHARMACY

PHARMACY NAME : ____________________________________ **ADDRESS:** __________________________________ **PHONE #:** _________________

I authorize Georgia Breast Care, PC and its affiliated providers to view my external prescription history via the RxHub service. I understand that prescription history from multiple other unaffiliated medical providers, insurance companies, and pharmacy benefit managers may be viewable by my providers and staff at Georgia Breast Care, PC. It may include prescriptions from the past several years.

My signature below certifies that I have read and understand the scope of my consent and I authorize access. The above information is true to the best of my knowledge. Also, we will file insurance with your provider according to your individual plan.

____ ___________________________

PATIENT SIGNATURE OR AUTHORIZED SIGNATURE **DATE**