Lillian Schapiro, MD
Desiree Clement,DNP

3200 Downwood Circle
Suite220
Atlanta,Ga. 30327

TEL: 404 312 3696

Today's Date: _____

Legal Name. _____ Date of Birth. _____
SSN#_____

Race: African American__ Native American __Asian __ Pac.Islander __ White/Caucasian ___ Patient Refused___

Ethnicity: Hispanic or Latino___ Non-Hispanic or Latino__ Patient Refused_____

Home address. _____ Apt# _____

City_____ State____ ZIP _____

Email _____ Cell phone _____

Employment: Full Time_____ Part Time_____ Self-employed _____ None_____

Employed by_____

Marital Status: Single __ Married__ Divorced ___ Widow___ Spouse's Name_____

Person authorized to discuss care: Name_____Relation_____Phone_____

Emergency Contact (Living with You). Name _____ Relation_____Phone_____

Emergency Contact (Not living with you) Name _____Relation_____Phone_____

Primary Care Physician _____ Phone _____

If MINOR, Responsible Adult Name_____ Relation_____

Address: _____ City/State/Zip_____ Phone_____

PRIMARY INSURANCE: Name_____ Effective Date_____ Phone_____

Policy Holder's Name _____ D.O Birth_____

ID# _____ Group #_____

Type of plan: HMO___ POS____ PPO____ EPO____ Indemnity_____ Commercial_____ Other_____

SECONDARY INSURANCE: Name_____ Effective Date_____ Phone_____

Policy Holder's Name _____ D.O Birth_____

ID# _____ Group #_____

Type of plan: HMO___ POS____ PPO____ EPO____ Indemnity_____ Commercial_____ Other_____

Authorization of Treatment:

I consent to examination, treatment and procedures, which may be performed during office visits including emergency treatment considered necessary by the physician and/or her designated provider.

Authorization for Release of Information/Receipt of Notice of Privacy Practices/Written Acknowledge form:

I authorize Ideal Gynecology to release to my insurance carrier and its designated agents any medical information, including information related to psychiatric care, drug or alcohol abuse, and HIV/AIDS, necessary to process any healthcare related utilization review or quality assurance activities. I further authorize the release of any medical information to any other providers to whom and from whom I have been referred for healthcare services or who provide consultative services regarding my medical care. This authorization shall remain in effect until revoked by me in writing. I know that I have a right to receive a copy of this authorization upon request and agree that a photocopy of same is as valid as the original.

SIGNATURE OF PATIENT OR GUARDIAN: _____ DATE: _____