North Atlanta Women's Specialists

Stacy I. Anand, M.D.
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John W. Donnelly, M.D.
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Arthur Gumer, M.D.
Carol B. Hess, C.N.P.
Robert J. Hirsch, M.D.
Erica P. Manogue, M.D.
Jeffrey A. Marcus, M.D.

Name ____
Last Name First Name Middle Name Maiden Name

Address ______________________ Last 4 digits of SS# ______________
______________________ Home Phone ______________
City & State Zip Code

Birthdate __________ Age ______ Marital Status S M W D Cell Phone ______________

Employed By ______________ Occupation ______________ Work# ______________

Address ____
Street City & State Zip Code

PATIENT'S E-MAIL ADDRESS: ______________________

In Case of Emergency Contact ______________ Phone Number ______________

Spouse's Name ______________ Work /Cell ______________

Referred by ______________ Religion (for medical purposes) ______________

INFORMATION ON INSURED (POLICY HOLDER)

Policy Holder's Name ____
Last Name First Name Middle Name

Address ____
Street City & State Zip Code

Home Phone No. ______________ Work Phone No. ______________

Employed By ______________ Employer's Address ______________

SS# ______________ Date of Birth ______________ Relationship to Patient ______________

INSURANCE INFORMATION

Primary Insurance		Secondary Insurance	
Name of Policy Holder		Name of Policy Holder	
Primary Insurance Address		Secondary Insurance Address	
Identification #		Identification #	
Group #	Effective Date	Group #	Effective Date
Date of Birth	Copay	Date of Birth	Copay

TREATMENT APPROVAL INSURANCE AUTHORIZATION

I hereby authorize North Atlanta Women's Specialists to treat me and to furnish information concerning my illness or treatment to an insurance carrier should it be necessary to process a claim. I authorize payment of medical benefits to North Atlanta Women's Specialists. I understand I am responsible for payment regardless of insurance coverage.

Signed ______________________________ Date ______________