Lillian Schapiro, MD
Daniel Geller, NP

3200 Downwood Circle
Suite 220
Atlanta, Georgia 30327
470-312-3696

Today's date _____ Referred by _____

Legal name _____ Date of birth _____

SSN# _____

Race: African American____ Native American____ Pacific Islander____ White/Caucasian____ Patient Refused____

Ethnicity: Hispanic or Latino_____ Non-Hispanic or Latino_____ Patient Refused_____

Home address _____ Apt # _____

City _____ State _____ Zip _____ Email _____

Employment: full-time ____ part-time____ self-employed_____ none____ Cell phone _____

Employed by _____ Home/Work phone_____

Marital status S M D W Spouse's name _____

Person authorized to discuss care (name/relation)_____

Emergency contact name, relation, phone (living with you) _____

Emergency contact name, relation, phone (not living with you) _____

Primary care physician _____ Phone _____

If MINOR, responsible adult/relationship _____

Address _____ City, State, Zip _____ Phone _____

PRIMARY INSURANCE Name _____ Effective date _____ Phone _____

Policy holder's name _____ Date of birth _____

ID# _____ Group number _____

Type of plan (circle one) HMO POS PPO EPO Indemnity Commercial

SECONDARY INSURANCE Name _____ Effective date _____ Phone _____

Policy holder's name _____ Date of birth _____

ID# _____ Group number _____

Type of plan (circle one) HMO POS PPO EPO Indemnity Commercial

Authorization for 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 other healthcare providers to whom or 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 _____