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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: _____

