



ALAN L. JOFFE, MD, F.A.C.O.G.
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993-C Johnson Ferry Road Suite 120 Atlanta, GA 30342
 3400-A Old Milton Parkway Suite 200 Alpharetta, GA 30005

DATE: _____

PATIENT INFORMATION

NAME: _____
LAST NAME FIRST NAME MIDDLE NAME MAIDEN NAME

ADDRESS: _____ HOME PHONE: () _____
STREET CITY/STATE ZIP CODE

CELL PHONE: () _____

BIRTHDATE: ____/____/____ AGE: _____ MARITAL STATUS: S M W D SOCIAL SECURITY NO. ____/____/____
(CIRCLE ONE)

EMPLOYED BY: _____ OCCUPATION: _____

ADDRESS: _____ WORK PHONE: () _____
STREET CITY/STATE ZIP CODE

SIGNIFICANT OTHER (SPOUSE) NAME: _____ SOCIAL SECURITY NO. ____/____/____

EMPLOYED BY: _____ WORK PHONE: () _____

IN CASE OF EMERGENCY, CONTACT: _____ PHONE: () _____

REFERRED BY: _____

NEAREST RELATIVE NOT LIVING WITH YOU: _____ PHONE: () _____

INFORMATION ON PERSON RESPONSIBLE FOR BILL

GUARANTOR NAME: _____
LAST NAME FIRST NAME MIDDLE NAME MAIDEN NAME

ADDRESS: _____ HOME PHONE: () _____
STREET CITY/STATE ZIP CODE

WORK PHONE: () _____

SOCIAL SECURITY NO. ____/____/____ RELATIONSHIP TO PATIENT: _____

EMPLOYED BY: _____ HOW LONG: _____ OCCUPATION: _____

INSURANCE INFORMATION

Do you have insurance to cover the FEES for services rendered? Yes No

PRIMARY INSURANCE		SECONDARY INSURANCE	
COMPANY: _____	INSURED DOB: ____/____/____	COMPANY: _____	INSURED DOB: ____/____/____
ADDRESS: _____	GRP #: _____	ADDRESS: _____	GRP #: _____
PHONE #: () _____	ID #: _____	PHONE #: () _____	ID #: _____

I authorize payment of medical benefits to Northside OB/GYN, P.C. for services rendered as described. I understand I am legally responsible for full payment such services regardless of insurance coverage.

I authorize the release of all medical information to Northside OB/GYN, P.C. which is necessary to process this claim. Additionally, I request payment of my Medicare benefits to myself or the party who accepts assignment. I also request the assignment of my Medicare benefits to Northside OB/GYN, P.C. in payment of this claim.

 SIGNATURE OF INSURED DATE SIGNATURE OF INSURED DATE