schilling HEALTHCARE

Patient Data Form

Mandatory

Clear Form

Complete - Print

1757 Rock Quarry Road
Stockbridge, GA 30281
T (770) 474-7151 F (770) 506-1915

SchillingWomensCenter.com

Patient ID: ←(FOR OFFICE USE) **Today's Date:**

SECTION A

Patient Name: _____ DOB: _____ Social Security #: _____

Address: _____

_____ Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widow

Mailing Address (if different): _____

_____ EMERGENCY CONTACT Name: _____

EMERGENCY CONTACT Phone: _____

Relationship: _____

☐ Home: _____

☐ Cell: _____ CHECK PREFERRED ←CONTACT NUMBER

☐ Work: _____

Email Address: _____ Can we discuss medical issues with this person? _____

How did you hear about us? _____ Any exceptions? _____

SECTION B

(*if*) Student - School: _____ Employed - Occupation: _____

Employer: _____ Employer PH #: _____

Employer Address: _____ City: _____ ST: ____ Zip: _____

PERSON FINANCIALLY RESPONSIBLE: _____ ←(If patient, skip to Section C)

Relationship: _____ DOB: _____ Social Security #: _____

(Please complete if home address is different from patient)

Home Address: _____ City: _____ ST: ____ Zip: _____

☐ Home: _____

☐ Cell: _____ CHECK PREFERRED ←CONTACT NUMBER

☐ Work: _____

Email Address: _____

(*Responsible party*) EMPLOYER: _____ Employer PH #: _____

Employer Address: _____ City: _____ ST: ____ Zip: _____

SECTION C

Name of **Primary** Insurance: _____ Policy #: _____

Insurance PH #: _____ Group #: _____

Are you the policy holder? ☐ Yes ☐ If NO, Please fill out next part of Section C (and D if applicable)

Policy Holder's Name: _____ Relationship to patient: _____

Sex: ☐ M ☐ F DOB: _____ Social Security #: _____

(Please complete if home address is different from patient)

Home Address: _____ City: _____ ST: ____ Zip: _____

EMPLOYER: _____ Employer PH #: _____

Employer Address: _____ City: _____ ST: ____ Zip: _____

SECTION D

Name of **Secondary** Insurance: _____ Policy #: _____

Insurance PH #: _____ Group #: _____

Policy Holder's Name: _____ Relationship to patient: _____

Sex: ☐ M ☐ F DOB: _____ Social Security #: _____

(Please complete if home address is different from patient)

Home Address: _____ City: _____ ST: ____ Zip: _____

EMPLOYER: _____ Employer PH #: _____

Employer Address: _____ City: _____ ST: ____ Zip: _____

Authorization to release information: I hereby authorize the Schilling Healthcare (dba Schilling Women's Center) to release any information acquired in the course of my treatment necessary to process insurance claims.

Authorization to pay benefits to Schilling Healthcare (dba Schilling Women's Center): I hereby authorize payment to Schilling Women's Center providers of the Surgical and/or Medical benefits, if any, otherwise payable to me for his/her services as described, realizing that I am responsible to pay non-covered services.

Signature: *Signature required at time of appointment **Date:** _____