CHARLES L. McCORD M.D., LLC

DBA GEORGIA OB/GYN

PATIENT INFORMATION

Date: _____

Last Name: _____ First: _____ Middle: _____
Address: _____ City: _____ State: ___ Zip Code: _____
Date of Birth: _____ Race: _____ Marital Status: S M W D Sep.
Telephone: (___) _____ Cell Ph: _____ SS#: _____
Employer: _____ (if student please fill in name of school)
Work address: _____
Work phone: _____ Length of employment: _____

Spouse's Name: _____ SS#: _____
Spouse's Employer: _____
Work Address: _____ Work Phone: _____

Emergency Contact: _____
(outside home) (name) (phone) (relationship)
Emergency Contact #2: _____
(outside home) (name) (phone) (relationship)

Complete this section ONLY if someone other than the patient is financially responsible.

Responsible Party: _____
(Full Name) (Relationship to patient)
Address: _____ City: _____ State: ____ Zip: _____
Birth Date: _____ SS#: _____ Home phone: _____
Employer: _____
Address: _____ City: _____ State: ____ Zip: _____
Length of Employment: _____ Work Phone: _____

ALLERGIES: (List if any) _____

How did you learn about our office? _____
Referred by: _____ Pharmacy Preference: _____

(Office use only: Pt. ID # _____)