PATIENT INFORMATION

Last Name _____ First Name _____ M.I. _____

Street Address _____

City _____ State _____ Zip _____

Billing Address (if different than above) _____

Home Phone # _____ Cell Phone _____

Best Number to call for test results (circle one): Cell Home Work

May we leave a detailed message on (circle one): Cell phone Home phone Neither

Employer _____ Work Phone # _____

Employer Address _____ Occupation _____

Sex: ____M _____F Marital Status: _____S ____M ____D ____W Birth Date _____

Social Security # _____ Email: _____

SPOUSE OR LEGAL GUARDIAN INFORMATION

Spouse/Parent or Guardian: _____

Birth Date: _____ Cell Phone # _____

Employer _____ Work Phone # _____

EMERGENCY CONTACT: Relative or Friend (Not Living with you)

Name _____ Relation _____ Phone # _____

Address _____ City _____ State _____ Zip _____

INSURANCE INFORMATION

PRIMARY Insurance _____ Policy Holder _____

Phone # _____ Birth Date of Insured _____

Policy # _____ Group # _____

SECONDARY Insurance _____ Policy Holder _____

HOW DID YOU HEAR ABOUT US?

Insurance Directory ___ Yellow Pages ___ Family/Friend _____ Other_____

ASSIGNMENT OF BENEFITS: I HEREBY AUTHORIZE PAYMENT DIRECTLY TO THIS Practice of benefits otherwise payable to me including major medical insurance and payment of surgical or medical benefits, but not to exceed the charges for these services. I understand that I am financially responsible for charges not covered by this assignment.

GUARANTEE OF ACCOUNT: For services rendered by this Practice, I hereby guarantee the payment of all accounts. For payment of said accounts for services I hereby waive all claims of exemption under the State of Georgia and agree to pay all costs of collection including Attorney's fees.

SIGNATURE _____ **DATE** _____

***Payment is expected at the time of service
including all copays, coinsurance and deductible amounts***