PLEASE PRINT CLEARLY!

Patient's First Name _____ Middle Initial _____ Last Name _____

Address _____

City _____ State _____ ZIP _____

Phone numbers Home (____) _____ Work (____) _____ Cell(____) _____

Date of Birth _____ Social Security # _____ Sex_____ Marital Status _____

Occupation _____ Employer _____

Primary Care Physician _____ Referred by: _____

If patient is a minor, please complete the following:
Child lives with Mother _____ Father _____ Both _____ Other _____

IN CASE OF EMERGENCY CONTACT: Name _____

Relationship _____ Phone number (_____)_____

INSURANCE & FINANCIAL INFORMATION
WE WILL NEED TO MAKE COPIES OF CURRENT INSURANCE CARD(S) & DRIVER'S LICENSE

Primary coverage, name of insurance company

_____

Subscriber's Name : _____

Address: _____

City _____ State _____ ZIP _____

Date of birth: _____ SS# : _____

Occupation: _____ Work # _____

Secondary coverage, name of insurance company

_____

Subscriber's name: _____

Address: _____

City _____ State _____ ZIP _____

Date of birth: _____ SS# : _____

Occupation: _____ Work # _____

Please give information on the person who is responsible for payment if other than person listed above

Name _____ Social Security # _____

Employer: _____ Business Phone: (_____)_____

I am aware that I am **responsible for all charges or any outstanding balances at the time of visit**. These charges may include deductibles, co-pays or other fees not covered by my insurance. I further agree that I will be responsible for any costs involved in collecting my account including, but not limited to, court fees and attorney fees.

Signature of responsible party _____ Date _____

We will be happy to discuss fees with you at any time and give any information which will assist you in determining benefits from your insurance carrier.

PAYMENT AUTHORIZATION

I hereby authorize Peachtree City Physicians Group to furnish information concerning my present illness. I direct the insurer to pay, without equivocation, directly to the physician, all benefits due him/her as a result of this claim. Although covered by insurance, I am aware that I am responsible for all charges. A photostatic copy of this authorization will be as valid as the original.

Signature of patient _____ Date _____
(parent or guardian if patient is a minor)