PRIMARY CARE PHYSICIANS OF ATLANTA, P.C.

PATIENT INFORMATION **DATE** _____

LAST NAME _____ FIRST NAME_____ MIDDLE INITIAL_____

ADDRESS_____

CITY_____ STATE_____ ZIP_____

SOCIAL SECURITY NUMBER _____ BIRTHDATE_____AGE_____SEX_____
(for claims-filing purposes)

HOME PHONE ( )_____ WORK PHONE ( )_____ CELL PHONE ( )_____

MARITAL STATUS _____ REFERRED BY _____

EMPLOYED BY _____ OCCUPATION_____

EMERGENCY CONTACT (not living with you)_____PHONE_____

RESPONSIBLE PARTY -- ☐ CHECK HERE IF SAME AS ABOVE --

LAST NAME _____ FIRST NAME_____ MIDDLE INITIAL_____

ADDRESS_____

CITY_____ STATE_____ ZIP_____

SOCIAL SECURITY NUMBER _____ BIRTHDATE _____
(for claims-filing purposes)

HOME PHONE ( )_____ WORK PHONE ( )_____ CELL PHONE ( )_____

INSURANCE INFORMATION

PRIMARY INSURANCE COMPANY NAME_____

CLAIM ADDRESS_____

CLAIM PHONE NUMBER ( )_____ID#/POLICY#_____

GROUP#_____ COPAY/COINSURANCE AMOUNT_____/_____

INSURED NAME_____ BIRTHDATE_____

RELATIONSHIP TO PATIENT_____

SECONDARY INSURANCE COMPANY NAME_____

CLAIM ADDRESS_____

CLAIM PHONE NUMBER ( )_____ID#/POLICY#_____

GROUP#_____ COPAY/COINSURANCE AMOUNT_____

INSURED NAME_____ BIRTHDATE _____

RELATIONSHIP TO PATIENT_____

I authorize the release of any medical information-, ***including information related to psychiatric care, drug, tobacco, alcohol or other substance abuse, genetic testing, and HIV/AIDS or other sexually-transmitted diseases,*** necessary to process insurance claims or any medical information that is needed for any utilization review or quality assurance activities. I assign all medical and/or surgical benefits to which I am entitled to Primary Care Physicians of Atlanta, P.C. I understand that I am fully responsible for all fees not covered by my insurance, including tests or procedures my insurance company deem "not medically necessary". In the event my account is turned over for collections, I agree to pay all fees incurred in the collection process. A photocopy of this authorization shall be considered as effective and valid as the original.

_____ _____

Patient (or Guardian) Signature Date