

Patient Information Form
Please Print One Character In Each Space

Patient Name: _____
(First Name) (Initial) (Last Name) (Suffix: Jr., MD)

Apt., Bldg., Unit, Etc.: _____

Street Address: _____

City: _____ **State:** _____ **Zip:** _____

Home Phone _____ **Emergency Phone:** _____

Emergency Contact Name: _____

Emergency Contact Relationship: _____

Birth Date: (MM/DD/YY) ____ / ____ / ____ **Sex:** M ____ or F ____ **Marital Status:** M, S, D, W ____
(Single) (Divorced) (Widowed)

Social Security Number: _____ (Required, if you want us to file your insurance.)

What is the name of the Doctor who referred you to us? _____ **Ph. #:** _____

Employer: _____

Suite, Bldg., Dept., Etc.: _____ **Street Address:** _____

City: _____ **State:** ____ **Zip:** _____

Work Phone: _____ **Extension:** _____

Primary Insurance

Effective Date: (MM/DD/YY) ____ / ____ / ____

Company Name: _____

Group #: _____

Policy #: _____ **Primary Care Physician:** _____ **Ph.** _____

Insured's Name (as it appears on the card) _____

Soc. Sec. Num.: _____ **Birth Date:** (MM/DD/YY) ____ / ____ / ____ **Sex:** M ____ or F ____

Please give your Insurance Card to the Receptionist so that we may make a copy for our records. If you have Supplementary Insurance, please allow us to copy those cards as well.

If the patient is minor, please complete the information on the reverse side of this form.

I hereby authorize the release of any medical information, including HIV/AIDS confidential information, necessary to process insurance claims or any medical information that is required for healthcare related utilization review or quality assurance activities. I authorize any physician, hospital, or clinic to provide details of my medical history to Georgia Colon & Rectal Surgical Associates, P.C. I hereby assign and authorize payment to Georgia Colon & Rectal Surgical Associates, P.C. of all medical and/or surgical benefits, including major medical benefits, to which I am entitled under any insurance policy or policies, under any self-insurance program or under any other benefit plan. I understand and acknowledge that this assignment of benefits does not relieve me of my financial responsibility for all medical fees and charges incurred by me or anyone on my behalf, and I hereby accept such responsibility, including, but not limited to: payment of those fees and charges not directly reimbursed to Georgia Colon & Rectal Surgical Associates, P.C. by any insurance policy, self-insurance program or other benefit plan. This authorization shall remain in effect until revoked by me in writing. A photocopy of this authorization shall be considered as effective and valid as the original. I understand that I have the right to receive a copy of this authorization.

Signature: _____ **Date:** _____