NORTH ATLANTA ENDOCRINOLOGY & DIABETES, P.C. (770) 339-1387

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PATIENT INFORMATION FORM

(PLEASE PRINT CLEARLY) SOCIAL SECURITY # ______________________

PATIENT'S NAME ______________________ (LAST) ______________________ (FIRST) __________ (MIDDLE)

HOME ADDRESS ______________________ (STREET) __________ (ZIP CODE) ______________________ (CITY) ______ (STATE)

GENERAL

HOME PHONE (______)______________ CELL PHONE (______) ______________ BIRTHDAY ______________

SEX: M / F RACE: ______________ MARITAL STATUS S M D W X U (CIRCLE ONE)

EMPLOYED: FULL PART TIME RETIRED NONE (CIRCLE ONE) STUDENT: FULL PART TIME NO (CIRCLE ONE)

EMPLOYER OR SCHOOL ______________________

ADDRESS ______________________ PHONE (______) ______________________

NAME OF SPOUSE (OR PARENT) ______________________

ADDRESS ______________________

SOCIAL SECURITY # OF SPOUSE (OR PARENT) ______________________ HOME PHONE (______) __________

SPOUSE (OR PARENT) EMPLOYER ______________________ WORK PHONE (______) __________

REFERRAL DOCTOR NAME AND PHONE ______________________

IN CASE OF EMERGENCY NEAREST RELATIVE / FRIEND NOT RESIDING AT THE SAME RESIDENCE AS YOURS:

NAME ______________________ PHONE (______) ______________

Please present your Insurance Card to the receptionist

INSURANCE

PRIMARY INSURANCE COMPANY ______________________

Insured Name ______________________ **Social Security #** ______________________

SECONDARY INSURANCE COMPANY ______________________

Insured Name ______________________ **Social Security #** ______________________

FINANCIAL

I HEREBY AUTHORIZE MY INSURANCE BENEFITS TO BE PAID DIRECTLY TO THE NAMES PROVIDED FOR PROFESSIONAL SERVICES RENDERED. I ALSO AUTHORIZE THE RELEASE OF ANY MEDICAL INFORMATION NECESSARY TO PROCESS ANY CLAIM FOR SERVICES RENDERED. I PERMIT A COPY OF THIS AUTHORIZATION TO BE USED IN PLACE OF THE ORIGINAL.

I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES FOR SERVICES RENDERED TO ME, OR MY DEPENDENT, INCLUDING THE BALANCE REMAINING AFTER PAYMENT OF POSSIBLE INSURANCE BENEFITS.

SIGNED ______________________ (PATIENT, OR GUARDIAN IF MINOR) DATE ______________

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