Patient Information

07-26-09

(last) (first) (mi) Today's Date: _____

Name:_____ _____ ___

How did you hear about us?

_____

Address: _____

_____

Primary Insurance

City/State/ Zip _____

_____

Social Security # _____

Secondary Insurance

Date of Birth _____

_____

Marital Status _____

Your Employer _____

Spouse's name _____

Spouse's SS# _____

Spouse's Date of Birth_____

Person Responsible for bill:

Self _____ Other _____

Relation to Patient _____

Primary care physician? _____

As part of your health care, Georgia Hormones will need to contact you from time to time, to remind you of an appointment, provide test results, give instructions, or to provide information.

I authorize Georgia Hormones to contact me in the following ways: Order of preference 1,2,3..

( )Home phone: ( ) _____.....OK to leave message Yes _____ No _____

( )Cell phone: ( ) _____.....OK to leave message Yes _____ No _____

( )Work Phone: ( ) _____.....OK to leave message Yes _____ No _____

( )Personal email _____OK to leave message Yes _____ No _____

( )Written note to home address……OK to leave message Yes _____ No _____

Signed _____ Date _____

I authorize any holder of medical or other information about me to release to my insurance company or to the Social Security Administration and Health Care Financing Administration or its intermediaries or carriers any information needed for this or a related Medicare claim. I permit a copy if this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself of to the party who accepts assignment. Regulations pertaining to medical assignment of benefits apply. **I UNDERSTAND THAT PAYMENT OF ALL CHARGES IS MY ULTIMATE RESPONSIBILITY, REGARDLESS OF INSURANCE COVERAGE.**

Signed _____ Date _____