Georgia Internal Medicine Partners, LLC.

Patient Registration Information

Patient's Personal Information

Name: _____ SS#: ____ - ____ -_____ DL#: _____

Marital Status: S / M / D / W Date of Birth: __ / __ / ____ Sex: M / F

Race:_____ Ethnic Group:_____ Primary Language:_____

Main phone#(___)_____ Alternate phone: (___)_____E-mail:_____

Address: _____ Apt#: _____

City: _____ State:_____ Zip:_____

Employer:_____ Occupation:_____

Work phone: (___)_____ Employer Address:_____

Emergency Contact:

Name:_____ Relationship:_____Phone #:_____

Guarantor Information Relationship to patient: ☐Self ☐Spouse ☐Father ☐Mother ☐Other_____

Name: _____ SS#: ____ - ____ -_____ DL#: _____

Date of Birth: ___ / ___ / ____ Main phone#: (___)_____ Alternate phone: (___)_____

Address: _____ Apt#: _____ City: _____ State:_____ Zip:_____

Employer:_____ Work phone: (___)_____

Patient's Insurance Information

Primary Insurance Company Name:_____ID#:_____
Group#: _____ Insurance Address: _____
Subscriber Name: _____ Date of Birth: ___ / ___ / ____
Subscriber's relationship to patient: ☐Self ☐Spouse ☐Father ☐Mother ☐Other_____ Copay: $_____
Secondary Insurance Company Name:_____ID#:_____
Group#: _____ Insurance Address: _____
Subscriber Name: _____ Date of Birth: ___ / ___ / ____
Subscriber's relationship to patient: ☐Self ☐Spouse ☐Father ☐Mother ☐Other_____ Copay: $_____

ALL MEDICARE PATIENTS MUST COMPLETE THIS SECTION
Are you receiving Black Lung Benefits? Yes _____ No _____
Are the services to be paid by a government research program? Yes _____ No _____
Are you entitled to benefits through the Department of Veterans Affairs? Yes _____ No_____
Was the illness/injury due to work-related accident/condition? Yes _____ No _____
Was the illness/injury due to a non-work related accident? Yes_____ No _____
Are you entitled to Medicare based on age? Yes_____ No _____
Are you entitled to Medicare based on End-Staged Renal Disease? Yes _____ No _____

I request that payment of authorized insurance benefits be made on my behalf to the provider indicated above for services furnished me. I authorize any holder of medical information about me or my dependent to release to the insurance company any information needed to determine these benefits or the benefits payable for related services. A photocopy of this assignment is to be considered as the original. I understand that I am financially responsible for all charges whether or not covered by said insurance. This assignment will remain in effect until revoked by me in writing. I further agree to pay the cost of collection, court costs, and other reasonable fees should they be required in the event of my non-payment. (If this patient is a minor child, the parent signing this form will be financially responsible for the child. Any legal agreement, or other disagreement, between parents in a divorce must be dealt with between those parties and does not involve Georgia Internal Medicine Partners, LLC. Patient Signature:_____
Date:_____