PATIENT REGISTRATION FORM

NAME
LAST ______________________________ FIRST _________________________ M.I._____ SEX: M F

ADDRESS _____________________________________ CITY _______________ STATE _____ ZIP_______

HOME PHONE (______)____________________ WORK # (_____)_____________________________

CELL PHONE (______)____________________ DOB ______/______/______

SOCIAL SECURITY # _________-________-_________ MARITAL STATUS: S M D W

EMPLOYER/SCHOOL______________________________________ OCCUPATION____________________

LOCAL FRIEND OR RELATIVE______________________________ PHONE (____)________________

INSURANCE COMPANY___________________________________ PHONE (____)________________

POLICY HOLDER NAME__________________ EMPLOYER_______________________ DOB___/___/___

ID # ______________________________ GROUP # ___________________ EFF. DATE:____________

SECONDARY INSURANCE COMPANY ______________________________ PHONE(___)___________

POLICY HOLDER NAME__________________ EMPLOYER_______________________ DOB___/___/___

ID # ______________________________ GROUP # ___________________ EFF. DATE:____________

REFERRED BY: PHYSICIAN NAME__________________________________ PHONE(___)___________

FAMILY___________________________ FRIEND______________________ OTHER_________________

AUTHORIZATION FOR TREATMENT
I consent to examination, treatment and procedures which may be performed during office visits including emergency treatment considered necessary by the physician and/or his designated provider.

ASSIGNMENT OF INSURANCE BENEFITS
I hereby assign payment directly to Infectious Disease Services of Georgia, P.C. for services covered by insurance or other health benefits plans.

AUTHORIZATION FOR RELEASE OF INFORMATION
I authorize Infectious Disease Services of Georgia, P.C. to release to my insurance carrier and its designated agents any medical information, including information related to psychiatric care, drug or alcohol abuse, and HIV/AIDS, necessary to process any healthcare related utilization review or quality assurance activities. I further authorize the release of any medical information to other healthcare providers to whom I have been referred for healthcare services or who provides consultative services regarding my medical care. This authorization shall remain in effect until revoked by me in writing.
I know that I have a right to receive a copy of this authorization upon request and agree that a photocopy of this authorization is as valid as the original.

SIGNATURE OF PATIENT OR GUARDIAN:__________________________ **DATE:**_________________