Georgia Clinic PC
P O Box 769609
Roswell, GA 30076-8224
USA
(866) 474-1934

PATIENT INFORMATION

NAME (Last, First Middle)	MRN	SSN#	BIRTHDATE	LANGUAGE	SEX

LOCAL ADDRESS	SECONDARY/BILLING ADDRESS (if Applicable)	ETHNICITY

CITY, STATE ZIP	HOME PHONE	CITY, STATE ZIP	SECONDARY HOME PHONE	RACE

PRIMARY CARE PHYSICIAN	REFERRING PHYSICIAN	CONTACT NAME	CONTACT HOME PHONE

PRIMARY EMPLOYER	SECONDARY EMPLOYER (if Applicable)
ADDRESS	ADDRESS
CITY, STATE ZIP	CITY, STATE ZIP
WORK PHONE	WORK PHONE

RESPONSIBLE PARTY INFORMATION (if Different than above)

NAME (Last, First Middle)	SSN#	BIRTHDATE	LANGUAGE	SEX

LOCAL ADDRESS	SECONDARY/BILLING ADDRESS (if Applicable)
CITY, STATE ZIP	CITY, STATE ZIP
HOME PHONE	SECONDARY HOME PHONE
RELATIONSHIP TO PATIENT	

PRIMARY INSURANCE

NAME OF INSURANCE COMPANY	POLICY#	
NAME OF INSURED	GROUP#	
ADDRESS OF INSURANCE COMPANY	COPAY AMT	
CITY, STATE ZIP	DEDUCTIBLE	
RELATIONSHIP TO PATIENT	EFFECTIVE DATE	EXPIRATION DATE

SECONDARY INSURANCE (if Applicable)

NAME OF INSURANCE COMPANY			POLICY#	
NAME OF INSURED	SSN#	BIRTHDATE	GROUP#	
ADDRESS OF INSURANCE COMPANY			COPAY AMT	
CITY, STATE ZIP			DEDUCTIBLE	
RELATIONSHIP TO PATIENT			EFFECTIVE DATE	EXPIRATION DATE

I certify that the information above is correct. I agree that insurance benefits for Georgia Clinic provider charges payable to the insured are to be made payable to Georgia Clinic P.C. and that physician benefits otherwise payable to the insured are to be made payable to Georgia Clinic P.C. Any payments received for services rendered to me by Georgia Clinic may be applied to any unpaid bills for which I am liable, subject to the rules of coordination of benefits. I acknowledge that I am fully responsible for all non-covered services, deductibles and co-payments. I further agree, in the event of default due to non-payment, to be responsible for collection fees, court costs, and/or legal fees, and there will be a $35.00 fee for all returned checks.

SIGNATURE OF PATIENT/GUARDIAN ____________________ DATE ____________