Villa Rica
Ear, Nose & Throat

NAME: _____ DATE OF BIRTH: _____

ADDRESS: _____ CITY, STATE, ZIP: _____

MAILING ADDRESS (IF DIFFERENT): _____

HOME #: _____ CELL #: _____ WORK#: _____ PREFERRED #: H C W

SS#: _____ RACE: _____ MARITAL STATUS: _____ SEX: _____

PRIMARY CARE DR: _____ REFERRING DR: _____

EMERGENCY CONTACT: _____ EMERGENCY PHONE #: _____

OCCUPATION: _____ EMPLOYER: _____

EMPLOYER ADDRESS: _____ CITY, STATE, ZIP: _____

SPOUSE'S NAME: _____ DOB: _____ SS#: _____

SPOUSE'S EMPLOYER: _____ PHONE #: _____

ADDRESS: _____ CITY, STATE, ZIP: _____

NAME OF PRIMARY INSURANCE: _____ ID#: _____

POLICY HOLDER: _____ COPAY: _____

GROUP #: _____ RELATIONSHIP TO PATIENT: _____

NAME OF SECONDARY INSURANCE: _____ ID#: _____

POLICY HOLDER: _____ COPAY: _____

GROUP #: _____ RELATIONSHIP TO PATIENT: _____

IF PATIENT IS UNDER 18 YEARS OF AGE, PLEASE FILL OUT THE FOLLOWING:

FATHER'S NAME: _____ MOTHER'S NAME: _____

FATHER'S ADDRESS: _____ MOTHER'S ADDRESS: _____

CITY, STATE, ZIP: _____ CITY, STATE, ZIP: _____

DOB: _____ SS#: _____ DOB: _____ SS: _____

EMPLOYER: _____ EMPLOYER: _____

WORK #: _____ CELL#: _____ WORK#: _____ CELL#: _____

AUTHORIZATION TO TREAT AND INSURANCE AUTHORIZATION

I assign to Chattahoochee Healthcare all payments for medical services rendered to me or my dependents. I authorize Chattahoochee Healthcare to furnish information to insurance carrier, physicians, or hospitals concerning illness and treatment. I authorize any physician, hospital or medical care facility to provide all information on medical history and treatment to Chattahoochee Healthcare. I authorize photocopies of this form to be valid as the original. I have read and understand the above and give Chattahoochee Healthcare permission to treat me or my dependents.

A copy of the Notice of Privacy Policy Practices is posted in the office and available upon request, Chattahoochee Healthcare DBA Villa Rica Ear, Nose and Throat.

SIGNATURE _____ DATE _____