PATIENT REGISTRATION FORM

ALL PATIENTS OR RESPONSIBLE PARTIES MUST COMPLETE THIS FORM AND PROVIDE A PICTURE ID AND INSURANCE CARD BEFORE SEEING A PROVIDER

LAST NAME ________________________________ FIRST NAME____________________ M.I. ____

ADDRESS ____ CITY____________________________

STATE _____________ ZIP __________ PHONE (H) _________________ (W)____________

(C): _____________________ EMAIL ADDRESS ____

SSN ____ - __ - ____ BIRTHDATE ______________ SEX (M) ____ (F) ____MARITAL STATUS: S M W D

ETHNICITY (please circle): African Am. Asian Caucasian/White Hispanic Indian/South Asian Native American

Other____ Refuse_____

EMERGENCY CONTACT NAME _____________________________RELATIONSHIP_______________

PHONE __________________________

INSURANCE CARRIER _______________________________________ INSURED'S SSN ____ - __ - ____

RELATIONSHIP TO PATIENT ____

INSURED'S EMPLOYER ____

EMPLOYER'S ADDRESS ____

SECONDARY INSURANCE CARRIER _____________________________ INSURED'S SSN ____ - __ - ___

INSURED'S NAME _______________________________INSURED'S BIRTHDATE _________________

PHARMACY INFORMATION: NAME: ____

ADDRESS: ____

____

PHONE: ____

IF A PATIENT IS A MINOR, COMPLETE THE FOLLOWING:

FATHER'S NAME ____PHONE ____________________

MOTHER'S NAME ____ PHONE ____________________

IN ORDER TO MAINTAIN CONTINUITY OF CARE, I GIVE PERMISSION TO PANDYA MEDICAL CENTER TO RELEASE MY MEDICAL RECORDS TO ANY SPECIALISTS, HOSPITALS OR MEDICAL FACILITIES ASSOCIATED WITH MY CARE PLAN. I UNDERSTAND THAT PANDYA MEDICAL CENTER ABIDES BY HIPAA REGULATIONS AND THAT ONLY THE RECORDS PERTINENT TO THE VISIT AND MY HEALTH WILL BE RELEASED.

SIGNED____ DATE: _____/_____/_____

3970 Deputy Bill Cantrell Memorial Rd.Ste 220,Cumming,GA 30040
3925-A Johns Creek Court, Suwanee, GA 30024
Ph. 770-709-6922 Fax. 770-709-6910

PATIENT REGISTRATION FORM

Authorization for Treatment and Assignment of Benefits

I authorize to receive treatment by Pandya Medical Center and its staff for the person named on this form. I authorize all insurance benefits to be paid directly to Pandya Medical Center.

____ _____/_____/_____

Name & Signature of Patient or Responsible Party Date

Release of Billing Information

I give my permission for Pandya Medical Center to bill my health insurance company for services provided to the named individual listed on this form. I agree and acknowledge that my signature on this document authorizes Pandya Medical Center to submit claims for services rendered without obtaining my signature on each and every claim to be submitted for myself and/or dependents and that I will be bound by this signature as though the undersigned had personally signed the particular claim.

During the course of my treatment at Pandya Medical Center I understand that there may be occasions for charges of non face-to-face visits, treatment recommendations, and/or review of records. I give my permission for Pandya Medical Center to bill my insurance company for these services and any amount deemed patient responsibility by the insurance company will be billed accordingly.

____ _____/_____/_____

Name & Signature of Patient or Responsible Party Date

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