Internal Medicine of Griffin

www.imgriffin.com

231 GRAEFE STREET
GRIFFIN, GA 30224

DATE:_____

PATIENT#_____ SS#_____

LAST NAME: _____ FIRST NAME: _____ MI:_____

ADDRESS 1:_____

ADDRESS2:_____

CITY: _____ STATE:_____ ZIP CODE:_____

HOME TELEPHONE #_____

WORK TELEPHONE#_____ EXT._____

MOBILE#_____

SEX: MALE FEMALE DATE OF BIRTH:_____

E-MAIL:_____

HOW DID YOU HEAR ABOUT US? _____

DOCTOR'S NAME FOR TODAY'S APPOINTMENT (CIRCLE ONE)

CROSS BOHN HITSON BARLOW DAY AHMED NAPIER HALL CHEWNING

DAS J.JOHNSON, PA-C WALK-IN A. COFER, PA-C J. SWATTS, PA-C L. MULLIS, NP

REFERRING DOCTOR: _____ PRIMARY DOCTOR: _____

MAIDEN NAME: _____ PATIENT EMPLOYER: _____

SPOUSE'S NAME: _____ SPOUSE'S EMPLOYER: _____

SPOUSE'S WORK#_____ EMERGENCY CONTACT :_____

EMERGENCY CONTACT#_____

Your signature below authorizes us to release information and/or receive payment from your insurance company for those services received from your physician or his associates named above.

By signing below, you are also stating that you are ultimately responsible for all changes incurred, regardless of insurance coverage.

SIGNATURE OF PATIENT (of Responsible Party):_____

LIFETIME AUTHORIZATION
FOR MEDICARE PATIENTS

I authorize any holder of medical or other information about me to release to the Social Security Administration and Health Care Financing Administration or its intermediaries or carrier any information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or to the party who accepts assignment. Regulation pertaining to Medicare assignment of benefits apply.

SIGNATURE: _____