PLEASE PRINT Name as it appears on Insurance Card **ACCT #**

( )Mr. ( ) Mrs. ( )Ms. ( ) Miss	First	Middle	Last	
Nickname if any:	Home Phone #	Cell Phone #		Work Phone #
Street Address		City	State	Zip
P O Box		City	State	Zip
Social Security Number		Birth Date(Month/Day/Year)	Age	Sex ( ) Male ( ) Female
Occupation or Retired		Employer		
Employer Street Address		City	State Zip	Phone #
Marital Status: ( ) Single ( ) Married ( ) Divorced ( ) Seperated ( ) Widowed		Name of Spouse		

NAME OF YOUR PRIMARY CARE DOCTOR:	**PHONE #** DATE LAST SEEN:
NAME OF ANY SPECIALIST PHYSICIANS	PHONE # DATE LAST SEEN:

How did you hear about us:

( ) Cartersville Yellow Pages ( )Marietta Yellow Pages ( ) Yellowbook ( ) On Line - please list Website -Name:

( ) Our Sign ( ) Walk-In ( ) Family Member ( ) Friend

( ) Physician - Name : ( ) Newspaper or Advertising - Name :

INSURANCE INFORMATION(PLEASE GIVE YOUR INSURANCE CARD AND DRIVERS LICENSE TO THE RECEPTIONIST)

Primary Insurance :	Policy Holder Date of Birth
Policy Holder's Employer:	Social Security Number
Address:	Work Phone #
Patient's Relationship to Policy Holder : ( ) Self ( ) Spouse ( ) Child ( ) Other	
Secondary Insurance :	Policy Holder Date of Birth
Policy Holder's Employer:	Social Security Number
Address:	Work Phone #
Patient's Relationship to Policy Holder : ( ) Self ( ) Spouse ( ) Child ( ) Other	

IN CASE OF AN EMERGENCY

Name of Friend or Relative not living at same address	Relationship to Patient	Phone number(s) to contact this person:

May we leave a message for you at: ( ) Home ( ) Work ( ) Cell

Regarding your: ( ) Appointment ( ) Test Results ( ) Medical Information

The about information is true to the best of my knowledge. I authorize my health plan to pay benefits directly to the physician. I understand that I am financially responsible for any co-pay, deductible, or non covered services. I agree to accept full financial responsibility for payment of charges rendered to the above patient.

X _____

Patient/Guardian Signature **Relationship to Patient** **Date**