NORTHEAST GEORGIA
HEART CENTER

WELCOME TO OUR OFFICE

General Patient Information

Last Name: ____________________________________ First Name: _________________________________ Middle Name: _______________

Address: ____ City/State/Zip Code: _____________________________________

Primary/Home Phone: ___________________________ Cell Phone: __________________________ Email: _____________________________

Social Security Number (SSN): ______________________________________ Date of Birth: ___________________________ Age: __________

Sex: ☐ Male ☐ Female

Marital Status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed ☐ Unknown

Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Unknown

Race: ☐ American Indian or AK Native ☐ Asian Black or African American ☐ Native Hawaiian or other Pacific Island ☐ White ☐ Other Race

Language: ☐ Arabic ☐ Chinese ☐ English ☐ French ☐ German ☐ Hebrew ☐ Italian ☐ Japanese ☐ Korean ☐ Portuguese ☐ Russian ☐ Spanish ☐ Swahili ☐ Undetermined

Employer: ____ Work Number: ____________________________

Employer Address: ____ City/State/Zip Code: ____________________________________

Spouse's Name: _______________________________ Date of Birth: _________________________ SSN: ______________________________

Spouse's Employer: ___________________________________ Occupation: ______________________ Work Phone: ______________________

Spouse's Employer Address: ____ City/State/Zip Code: ___________________________________

Who referred you to this practice/who is your primary care physician? ____

Person(s) we may contact or release information regarding your medical/financial care:

Name	Relationship	Phone Number
____	___________________________________	_____________________________
____	___________________________________	_____________________________

Emergency Contact:

Name	Relationship	Phone Number
____	___________________________________	_____________________________

Insurance Information:

Primary Insurance: __________________________ Secondary Insurance: _______________________

Name of Insured: ____________________________ Name of Insured: ___________________________

Group Number: ______________________________ Group Number: _____________________________

Policy Number: ______________________________ Policy Number: ____________________________

Consent to treatment

I consent to treatment by the physicians and staff of Northeast Georgia Heart Center, PC.

Insurance Authority & Assignment

I request that payment of authorized Medicare/Other Insurance company benefits be made to **Northeast Georgia Heart Center, PC** for any services furnished me by that party who accepts assignment/physician. Regulations pertaining to Medicare assignment of benefits apply. The patient is responsible for the deductible, co-insurance, and non-covered services which is the charge determination of your insurance company. I acknowledge receipt of a copy of the Financial Policy for Northeast Georgia Heart Center, PC.

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 carriers any information needed for this or a related Medicare claim/other Insurance Company 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. I understand it is mandatory to notify the health care provider of any other party who may be responsible for paying for my treatment.

I acknowledge that I have received a copy of the Notice of Privacy Practices for the Northeast Georgia Heart Center, PC.

Patient's Signature ____ Date: _____________________