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ATLANTA CLINICAL CARE

INFECTIOUS DISEASES & INFUSION SERVICES

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Today's Date: _____________

Personal Data

Full Name: ________________________ Date of Birth: ___________ Age: _____ Sex: ○ M ○ F

Address: ________________________ Marital Status: ○ S ○ M ○ D ○ W ○ Other: ___________

Home Phone: ______________ Work Phone: ______________ Cell Phone: ________________ Race: ____________________

Preferred Phone: ○ Home ○ Work ○ Cell Email: ______________________ Social Security #: ________________

Employment Data

Employer Name: ______________________ Job Title: ________________ Dept: ______________________

Employer Address: ______________________________ Work Phone: ______________ Ext: ______

May We Leave Messages For You At Work? ○ Yes ○ No

Responsible Party

Name: ________________________ Date of Birth: ___________ Age: _____ Sex: ○ M ○ F

Address: ________________________ Primary Phone: ______________ Alternate Phone: ____________

Relationship: ____________________ Employer: ________________________________

Insurance Data *Please Present Insurance Card And Photo Id At The Time Of Your Office Visit*

Insurance Company: ___________________ Policy/Id #: _______________ Group #: ____________ Phone: ____________

Address: ______________________________ Policyholder Name: ________________________

Policyholder Date Of Birth: ______________ Relationship To Patient: ○ Self ○ Spouse ○ Child ○ Other: ______________

Secondary Insurance Data

Insurance Company: ___________________ Policy/Id #: _______________ Group #: ____________ Phone: ____________

Address: ______________________________ Policyholder Name: ________________________

Policyholder Date Of Birth: ______________ Relationship To Patient: ○ Self ○ Spouse ○ Child ○ Other: ______________

Emergency Contact Data (Nearest Relative/Friend Not Living With You)

Name: ___________________ Relationship: _______________ Home Phone:______________ Work Phone:______________

Name: ___________________ Relationship: _______________ Home Phone:______________ Work Phone:______________

If You Would Like Prescriptions Sent Directly To Your Pharmacy, Please Provide:

Preferred Pharmacy: ___________________ Phone: ______________ Address: ______________________________

Preferred Method Of Communication? ○ Phone ○ Mail ○ Patient Portal

May Our Practice Access Your Electronic Rx History? ○ Yes ○ No (See Office Manager)

I HEREBY AUTHORIZE PAYMENT OF INSURANCE BENEFITS OTHERWISE DUE TO ME BE MADE DIRECTLY TO THE ABOVE PHYSICIAN. I UNDERSTAND THAT I AM RESPONSIBLE FOR ANY AMOUNT NOT COVERED BY THE INSURANCE COMPANY. I HEREBY AUTHORIZE THE ABOVE PHYSICIAN TO OBTAIN RECORDS FROM OTHER SOURCES AS MAY BE NEEDED IN THE TREATMENT OF THIS PATIENT. I HEREBY AUTHORIZE THE RELEASE OF ANY INFORMATION CONCERNING THIS PATIENT'S TREATMENT TO OTHER PHYSICIANS INVOLVED IN THE TREATMENT OF THIS PATIENT. I HEREBY AUTHORIZE THE RELEASE OF INFORMATION TO THE INSURANCE COMPANY AS NEEDED TO FILE FOR CHARGES INCURRED BY THE PATIENT.

SIGNATURE OF PATIENT OR RESPONSIBLE PARTY

SIGNATURE: ________________________________ DATE: ____________