Atlanta Surgery Associates

REGISTRATION FORM

(Please Print)

Today's Date _____/_____/_____ Primary Care Physician_____

PATIENT INFORMATION

Patient's Last Name	First	Middle	❑ Mr. ❑ Miss ❑ Mrs. ❑ Ms.	Marital Status (Circle One) Single / Mar / Div / Sep / Wid

Is this your legal name? ❑ Yes ❑ No	If not, what is your legal name?	(Former Name)	Birth Date / /	Age	Sex ❑ M ❑ F

Street Address	City	State	ZIP Code	Social Security	Home Phone No. ( )

P.O. Box	City	State	ZIP Code

Email Address	Employer/Occupation	Employer Phone No. ( )

Chose Office Because/Referred to Office by (Please check one box) ❑ Dr. _____ ❑ Insurance Plan ❑ Hospital

❑ Family ❑ Friend ❑ Close to Home/Work ❑ Online ❑ Other _____

Other Family Members Seen Here _____

INSURANCE INFORMATION (PLEASE GIVE YOUR INSURANCE CARD TO THE RECEPTIONIST)

Person Responsible for Bill	Birth Date / /	Address (if different)	Home Phone No.
Is this person a patient here?	❑ Yes ❑ No		( )

Occupation	Employer	Employer Address	Employer Phone No. ( )

Is this patient covered by insurance? ❑ Yes ❑ No

Please indicate primary insurance

Subscriber's Name	Subscriber's S.S. #	Birth Date / /	Group #	Policy #	Co-Payment $

Patient's Relationship to Subscriber ❑ Self ❑ Spouse ❑ Child ❑ Other _____

Name of Secondary Insurance (if applicable) Subscriber's Name	Group #	Policy #

Patient's Relationship to Subscriber ❑ Self ❑ Spouse ❑ Child ❑ Other _____

IN CASE OF EMERGENCY

Name of Local Friend or Relative (not living at same address)	Relationship to Patient	Home Phone No. ( )	Work Phone No. ( )

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Atlanta Surgery Associates or insurance company to release any information required to process my claims.

X _____

PATIENT/GUARDIAN SIGNATURE DATE

ATLANTA SURGERY ASSOCIATES

550 Peachtree St N. Ste 1430
Atlanta, GA 30308
Phone (404) 221-1095

1129 Hospital Dr. Ste. 1A
Stockbridge, GA 30281
(678) 289-5155

Protected Health Information Release Form:

Patient Name: _____ Date: _____

(1) Concerning matters of my health, I give permission for Atlanta Surgery Associates or a member of the staff to speak with:

Name of person(s) _____ relationship to patient _____

Name of person(s) _____ relationship to patient _____

Name of person(s) _____ relationship to patient _____

Name of person(s) _____ relationship to patient _____

2) I request that use and disclosure of the above described information be restricted in the following manner [description of restriction]:

_____

_____

(3) I request that my protected health information not be disclosed to the following individuals or entities [list individuals or entities to which information would not be disclosed]:

_____

_____

Signature of patient: _____

Witness: _____