

ENT of GEORGIA, PC

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Stockbridge, GA 30281
(770) 389-0000 Fax: (770) 389-0168

Doctor _____

Name or Initials of Check-in Clerk

PATIENT INFORMATION

Name: _____ Patient ID #: _____ Sex: () M () F
Address: _____ Date of Birth: _____

Social Security #: _____
City, State: _____ Marital Status: () Married () Single () Divorced
Zip Code: _____ Referring Physician: _____
Home Phone: _____ Primary Physician: _____
Work Phone: _____ E-Mail Address: _____

Emergency Contact:
(Someone who does not live in your household)

Name: _____ Address: _____
Phone # _____ Relationship to Patient: _____

PATIENT EMPLOYMENT

() Employed () Retired () Other

PRIMARY INSURANCE

() Same as Patient () Primary Insured () Other

Insured Party: _____ Relationship to Patient: _____
Co-pay Amount: _____ Social Security #: _____
Insurance Company: _____ Insured ID #: _____
Policy Group #: _____ Date of Birth: _____
Employer Name: _____ Employer Phone #: _____

SECONDARY INSURANCE

() Same as Patient () Primary Insured () Other

Insured Party: _____ Relationship to Patient: _____
Co-pay Amount: _____ Social Security #: _____
Insurance Company: _____ Insured ID #: _____
Policy Group #: _____ Date of Birth: _____
Employer Name: _____ Employer Phone #: _____

RELEASE: I hereby authorize the undersigned Physician to release to insurance Carriers any information required to process claims regarding services and treatment provided.

Signature: _____ Date: _____

AUTHORIZATION: I hereby assign payment to the undersigned physician. I understand that I am financially responsible for the non-covered services.

Signature: _____ Date: _____