



Patient Information - Please Print Clearly

Patient's Name _____ SS# _____ - _____ - _____ Birth Date ____/____/____
Spouse _____ Guardian's Name if Minor _____
Street Address _____ Sex _____ Age _____
City _____ State _____ Zip Code _____
Phone: Home _____ - _____ - _____ Work _____ - _____ - _____ Cell _____ - _____ - _____
Referred By _____ Marital Status _____ Driver's License # _____
Patient's Employer _____ Occupation (Indicate if Student) _____
Employer's Address _____ City/State _____ Zip Code _____

Insurance Information

- Primary Insurance Company** _____ Policy # _____
Policy Holder's Name _____
Insurance Policy Holder's Employer _____ Group # _____
Policy Holder's Relation to Patient _____
Home Phone # _____ - _____ - _____ Work Phone # _____ - _____ - _____
Policy Holder's Date of Birth ____/____/____ Policy Holder's SS# _____ - _____ - _____
- Secondary Insurance Company** _____ Policy # _____
Policy Holder's Name _____
Insurance Policy Holder's Employer _____ Group # _____
Policy Holder's Relation to Patient _____
Home Phone # _____ - _____ - _____ Work Phone # _____ - _____ - _____
Policy Holder's Date of Birth ____/____/____ Policy Holder's SS# _____ - _____ - _____

Emergency Contact (Other than Spouse) _____
Relationship _____ Phone # _____

We require all patients to show their insurance or managed care membership card and their driver's license so that we may make copies for our permanent records.

We cannot render services on the assumption that our charges will be paid by an insurance company. If no proof of insurance is presented at time of service, all services will be charged directly to the patient and he or she remains personally responsible for payment. As a courtesy, however, we will prepare any necessary reports and itemizations to assist in making collections from insurance companies and will credit any such collection to the patient's account.

We use the following outside facilities to assist in some of the tests we perform: Henry County Radiology and Atlanta Heart Associates read our radiology films; Lab tests that cannot be processed in our office are sent to Quest Diagnostics or LabCorp (depending on your insurance). These facilities bill your insurance company directly for their services.

Payment and Release of Information Authorization

I, _____, hereby authorize Eagle's Landing Family Practice, Inc., to furnish information concerning my present illness. I direct the insurer to pay without equivocation, directly to the physician, all benefits due him as a result of this claim. Although covered by insurance, I am aware that I am personally responsible for all charges. I agree to pay any collection and/or attorney fees associated with my failure to pay my debt. A photo static copy of this authorization will be valid as the original.

I hereby authorize Eagle's Landing Family Practice, Inc., to release the medical information contained in my chart to my insurance carrier for the purpose of conducting chart reviews, as necessary. I acknowledge and agree that I may be evaluated and treated by either a Physician Assistant or Registered Nurse Practitioner. I understand that I may request to be scheduled for an evaluation with a Physician at the next reasonably available appointment time.

I understand that, if a radiology test or lab test is performed on me at Eagle's Landing Family Practice, Inc., my insurance will be billed by the outside facility for services rendered. If my insurance fails to pay, I understand I am responsible for the charges due to the facility assisting in my care.

Signature of Patient/(Guardian) _____ Date ____/____/____