PATIENT INFORMATION

Date_____ Soc. Sec. #_____ Birthdate _____ Age_____

Name _____
LAST NAME FIRST NAME INITIAL

Address _____ Home Phone _____

City _____ State _____ Zip _____

Sex _____ Single_____ Married_____ Divorced_____ Widowed_____

Height _____ (FT) _____ (IN) Weight _____

Employer _____ Business Phone _____

Business Address _____ Occupation _____

Who should we thank for referring you? _____

In Case of emergency, who should we contact? _____

PRIME INSURANCE

Person Responsible for Account _____
Last Name First Name Initial

Relationship to Patient _____ Birthdate _____ Soc. Sec. #_____

Insurance Company _____

Subscriber I.D.# _____ Group # _____

ASSIGNMENT AND RELEASE

I here authorize payment directly to Surgical Associates of Atlanta for all insurance benefits otherwise payable to me for services rendered. I understand that I am financially responsible for all charges, whether or not paid by insurance, and for all services rendered on my behalf or dependents.

I authorize the above doctor and/or any provider or supplier of services in this office release the information required to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Signature of Responsible Party _____