

Patient Information Update Form

You may print this and bring it with you for your appointment, or fax it to 678-985-1999. Appt Date: _____

Please fill out each section completely.

Patient Name: _____ Date of Birth: _____ Age: _____

CIRCLE ONE: Gender: Male / Female CIRCLE ONE: Marital Status: S W M D Race: _____

Mailing address: _____ City/State _____ Zip _____

County of Residence: _____

Daytime Phone: _____ Evening: _____ Alternate: _____

Social Security No. _____

Your ss# is required if you wish for SGA to file to insurance. Thank you for your cooperation.

Emergency Contact: _____

Phone: _____

Primary Insurance Policy Information

Insurance Company: _____

Name of Policyholder: _____ Date of Birth: _____

The policyholder is the person who carries the insurance policy.

Member ID: _____ Group or Group#: _____

Relation to patient:

patient spouse child other _____

SS of policyholder: _____

Secondary Insurance Policy Information

Insurance Company: _____

Name of Policyholder: _____ Date of Birth: _____

The policyholder is the person who carries the insurance policy.

Member ID: _____ Group or Group#: _____

Relation to patient:

patient spouse child other _____

SS of policyholder: _____

Primary Care Physician: _____ Phone: _____

Whom may we thank for your referral? _____

Please present your drivers license and insurance card(s) to the receptionist. If you do not have a copy of your insurance card and you are not able to obtain one, you will be considered a Self-Pay patient. Payment is due at the time of service, or you may reschedule your appointment.

It each patient's responsibility to obtain a referral if your insurance requires one. If you have not provided our office with a referral at check-in, you will be considered a Self-Pay patient. Payment is due at time of service, or you may reschedule your appointment. COPAYMENTS ARE DUE AT CHECK-IN.

I hereby authorize the release of any medical information, including HIV/AIDS confidential information necessary to process insurance claims or any medical information that is required for healthcare utilization review or quality assurance activities. I authorize any physician, hospital, or clinic to provide details of my medical history to SGA. I hereby sign and authorize payment to SGA for charges incurred by me or on my behalf. I hereby accept responsibility for all medical fees and charges incurred by me or on my behalf, and I accept responsibility for payment. This agreement shall remain in effect until revoked by me in writing. A photocopy of this agreement shall be considered as effective and valid as the original. I understand that I have a right to receive a copy upon request.

Do we have permission to release information contained in your chart to any family member over the phone?

For instance: Appt information and lab results? YES NO

If yes, to whom specifically may the information be released?: _____

Signature: _____ Date: _____