

Patient Information
 Infectious Disease Specialists of Atlanta, P.C.

Account #			Date:		
Patient Name (Last, First, Middle Initial):			Date of Birth:		
Address:					
City:		State:		Zip Code:	
Home Phone #		Work Phone #		Cell Phone #	
Age:	Sex: (M/F)	Marital Status: (S/M/D/W)		Social Security #	
Employer:			Work Phone #		
Employer Address:			City, State, Zip:		
Person Responsible For Payment of Bill:			Relationship to Patient:		
Billing Address (City, State, Zip Code):					
Responsible Party Date of Birth:			SS #		
Responsible Party Employer:					
Employer Address:					
Spouse's Name:			Work #		Cell #
Nearest relative/friend not living with you:			Phone #		Cell #
Who referred you to the practice?					
Insurance Information					
Is this a work-related injury?			Date of Injury:		
Primary Insurance Name:			Insured Name:		
Relationship to Insured:			Insured's Date of Birth:		
Insurance Address:					
ID or Policy #		Group #		PCP:	
Effective Date:		HMO/PPO (Circle one)		Co-payment:	
Secondary Insurance Name:			Insured Name:		
Relationship to Insured:			Insured's Date of Birth:		
Insurance Address:					
ID or Policy #		Group #		Effective Date:	
HMO/PPO (Circle one)			Co-payment:		
Please list additional insurance:					
Financial Statement and Release of Information					
I hereby authorize payment of medical benefits directly to the physician or supplier for services as described, realizing I am the responsible party. I authorize the release of any medical or other information necessary to process insurance claims.					
Signature: _____					Date: _____