PERIMETER CLINIC ATLANTA

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Phone: 770-351-0900
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PATIENT INFORMATION FORM

Please provide all requested information that we will use as part of your medical record and billing purposes

First Name: _____ Middle Initial _____ Last Name _____

Patient SSN: _____ Date of Birth: _____ Sex: F or M

Home Phone #: _____ Cell Phone #: _____

Email Address: _____

Address (No PO Boxes): _____ Apt #: _____

City: _____ State: _____ ZIP: _____

Primary Care Physician Name: _____ Phone: _____

Payment made today will be applied by:

I will be paying today using (circle one): Cash Visa Master Card AMEX
Perimeter Clinic does not accept personal checks

Insurance Information(Copies of insurance cards required. Please fill out the insurance information only if you do not have an insurance card. If the policyholder is someone other than you please provide policyholders information.)

Employer or Insured Person: _____ Policy Holder: _____
Insurance Carrier: _____ Member ID #: _____
Group #: _____ Phone Number: _____
Claims Address: _____ City: _____ ST: _____ Zip: _____

Do you have a second insurance: _____ Yes _____ No
If yes, name of secondary insurance carrier: _____ Policy Holder: _____
Member ID#: _____ Group#: _____
Claims Address: _____ City: _____ ST: ____ Zip: _____

Notify in Case of an Emergency:

Name: _____ Phone #: _____

I hereby assign and authorize payment to Perimeter Clinic for all medical benefits to which I am entitled to under my insurance policy. I understand and acknowledge that this assignment of benefits does not relieve me of my financial responsibilities for all medical fees and charges incurred by me. This authorization will remain in effect until revoked by me in writing. I am aware that the practice of medicine is not an exact science and I acknowledge that no guarantees have been made to be as the result of treatments, exams, or medical care.

I acknowledge all information provided is current and accurate.

Patient's signature or guardian: _____ Date: _____