Buckhead Internal Medicine

Registration Form

(Please Print)

Today's date:	PCP:

PATIENT INFORMATION

Patient's last name: First: Middle:	❑ M ❑ F	Marital status (circle one) Single / Mar / Div / Sep / Wid

Birth date: / /	Age:	Home Phone: ( )	Day Phone: ( )	Mobile: ( )

Street address:	Social Security no.:	Student: ❑ Part-time ❑ Full-time

P.O. box:	City:	State:	ZIP Code:

Occupation:	Employer:	Employer Phone:

Referred By :

Spouse Name:	Other Family Members Seen Here:	E mail Address:

INSURANCE INFORMATION

(Please give your insurance card to the receptionist.)

Person responsible for bill:	Birth date: / /	Address (if different):	Home Phone: ( )

Street address:	City:	State:	ZIP Code:

Subscriber's name:	Subscriber's S.S. no.:	Birth date: / /	Group no.:	Policy no.:	Co-payment: $

Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other

Name of secondary insurance (if applicable):	Subscriber's name:	Group no.:	Policy no.:

Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address):	Relationship to patient:	Home Phone: ( )	Day Phone: ( )

Patient/Guardian signature *Date*