Gwinnett Internal Medicine Associates, LLC

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Patient Information

Patient's Name: ___ _____ **Date of Birth:** _____

Social Security #: _____ **Gender:** _____ **Male** _____**Female**

Address: _____ **Telephone #:**_____

City: _____ **State:** _____ **Zip:** _____

Cell #: _____ **Email Address:** _____

Employer: _____ **Work Ph. #:** _____

Emergency Contact: _____ **Phone #:** _____

Referred to office by: _____ **Relative** _____ **Friend** _____**Website** _____ **Ins. Co.**

Insurance Information

Name of Insured: _____ **Insured's DOB:** _____

Insured's Employer: _____ **Telephone #:** _____

Insurance Co: _____ **Telephone #:** _____

Insurance ID #: _____ **Group #:** _____

Primary Care Physician Listed on Insurance Card: _____

I hereby authorize the release of any medical information to any insurance company or institution with whom I have medical benefits for the purpose of filing a medical claim. I also authorize my insurance carrier to pay Gwinnett internal Medicine Assoc. LLC for the charges I have incurred.

I understand that payment is due when services are rendered unless prior arrangements have been previously made. I also understand that I accept responsibility for all charges incurred.

_____ _____

Patient or Authorized Signature **Date**