PATIENT INFORMATION

Last Name	First Name	M.I

Street Address	City	State	Zip
Mailing Address (if not same as above)	City	State	Zip

Home ph #	Work ph #	Cell #

Birthday(mm/dd/yy)	Sex: M F	SSN:	Driver's license # and state

Email Address:	Martial Status: Single____ Married____ Divorced____ Widow/Widower____
Race: White ____ African American____ Hispanic____ East Indian ____ Southeast Asians ____ Other ____	Ethnicity: Language:
Employer	Employer Phone
Primary Care Physician: (PCP)	PCP Telephone #:

EMERGENCY CONTACT

Name	Relationship	Telephone # ( )

Address	City	State	Zip

INSURANCE INFORMATION

Insurance Company	Policy Holder's Name	Birthday	SSN

Member ID Number	Group Number	Employer
Patient relationship to Insured: Self Spouse Child Other:		

Additional Insurance Company	Policy Holder's Name	Birthday	SSN

Member ID Number	Group Number	Employer
Patient relationship to Insured: Self Spouse Child Other:		

HOW DID YOU HEAR ABOUT US?

□ Referred By □ Ins. Directory □ Friend □ Yellow Pages □ Direct Mail □ Physician □ LA Fitness

Referral's Name	Referral Phone Number ( )

I _________DO __________DO NOT (Please initial) **GIVE PERMISSION TO HAVE MY HEALTH INFORMATION SHARED WITH MY CHILDREN AND SPOUSE OR: ____.**

Do you currently have an Advanced Directive? Please list the responsible party for this document ______________________________

AUTHORIZATION FOR RELEASE OF INFORMATION- I hereby authorize this practice to furnish any medical information requested by insurance companies with whom I have coverage or any public agency which may be assisting in payment of my care.

ASSIGNMENT OF BENEFITS- I hereby authorize payment directly to this practice of benefits otherwise payable to me including major medical insurance and payment of surgical or medical benefit, but not excess the charges for these services understand that I am financially responsible for charges not covered by this assignment.

GUARANTEE OF ACCOUNT- For service furnished by Atlanta Heart Specialists, LLC., I hereby guarantee the payment of all account for service rendered. For payment of said accounts for service I hereby waive all claims of exemption under the State Of Georgia to pay, if necessary, all costs of collection, including attorney's fee.

Signature ____ Date ___________________________________