PATIENT INFORMATION
Please complete each line of registration

Primary Doctor: (Circle one) **Ellis** **Culpepper** **Bramwell**

Name: (Last) _____ **(First)** _____ **(Middle)** _____

Address: _____**City:**_____

State: _____**Zip:** _____ **County**: _____**DOB:** _____ **Sex: M F SS#** _____

Cell: (____) _____**Work:** (____) _____ **Home:** (____) _____

Race: _____ **Marital Status:** _____ **E-mail for Web Portal:** _____

How were you referred to our office: _____

Patient's Employer Name: _____**Occupation:** _____

Spouse or Parent's Name: _____**Employer:** _____

Pharmacy Name: _____**Phone:**_____

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

IF THIS SECTION IS NOT COMPLETE, INSURANCE CAN NOT BE FILED

Insured (card holder/employee): Self Spouse Parent Other

Insured's Information:

Name(s): _____Relationship: _____

Date of Birth: _____/_____/_____SSN: _____Cell Number: (_____) _____

Bus. Phone: (_____) _____ Ext: _____ Home Phone: (_____) _____

Insurance Coverage Information, Need To Complete

Primary Ins.		Secondary Ins.	
Policy Holder		Policy Holder	
ID Number		ID Number	
Group Number		Group Number	

Emergency Contact Information:

Name: _____

Telephone: (_____) _____Relationship: _____ Do you have a living will? Yes No

Payment Responsibility

All professional services rendered are charged to the patient. We will file insurance claims for the patient if the patient is covered by an insurance plan with which our office has a negotiated contract. If the patient is not covered by an insurance plan that our office has a negotiated contract with, it is the responsibility of the patient to pay for services when rendered, regardless of insurance coverage.

Insurance Authorizations: Release of Information/Electronic Prescribing

I authorize the release of any medical or other information necessary to process my insurance claims for my child, or myself. I authorize release of information to other providers of service needed for continuation of my medical care, such as specialists, hospitals etc. I request that payment of authorized benefits is made on my behalf to North Chattahoochee Family Physicians, LLC for any services furnished me by that party who accepts assignment. I permit a copy of this authorization to be used in place of the original and request payment of medical insurance benefits to the party who accept assignment. I understand it is mandatory to notify the health care provider of any party who may be responsible for my treatment. I authorize provider to electronically prescribe medication directly to my pharmacy.

Signature: _____**Date:** _____

Notice of Privacy Practices (HIPAA): Signature_____**Date**_____