



**INMAN PARK PHYSICIANS**

**Atlanta Medical Center**

Today's Date \_\_\_\_\_

How did you find Inman Park Physicians? \_\_\_\_\_

Patient Last name \_\_\_\_\_ First Name \_\_\_\_\_

Birthdate \_\_\_\_\_ SSN \_\_\_\_\_ Sex \_\_\_\_\_ Marital Status \_\_\_\_\_

Home address \_\_\_\_\_

Email address \_\_\_\_\_

Home phone \_\_\_\_\_ Work phone \_\_\_\_\_ Cell phone \_\_\_\_\_

Employer name & address \_\_\_\_\_

How would you like the practice to contact you? \_\_\_\_\_

Emergency contact person \_\_\_\_\_

Relationship to you \_\_\_\_\_ Phone \_\_\_\_\_

Primary insurance name \_\_\_\_\_

Policy holder \_\_\_\_\_ Birthdate \_\_\_\_\_

Policy number \_\_\_\_\_ Group number \_\_\_\_\_

Secondary insurance name \_\_\_\_\_

Policy holder \_\_\_\_\_ Birthdate \_\_\_\_\_

Policy number \_\_\_\_\_ Group number \_\_\_\_\_

**Assignment for treatment. Permission is hereby given for medical diagnosis and /or treatment as may be deem advisable or necessary by the medical staff of Inman Park Physicians of Atlanta Medical Center.**

Signature \_\_\_\_\_ Today's Date \_\_\_\_\_

**Release of Medical Information. I authorize the release of any medical or other information necessary to process claims pertaining to my medical treatment.**

***\*This information is strictly confidential and used only for your medical care\****

Signature \_\_\_\_\_ Today's Date \_\_\_\_\_

**Assignment of Benefits. I authorize payment of medical benefits to Inman Park Physicians of Atlanta Medical Center, or our authorized billing service. I understand it is my responsibility to inform this office of any change in my insurance service.**

Signature \_\_\_\_\_ Today's Date \_\_\_\_\_