



Adult Medicine Of Marietta PC

790 Church Street
 Marietta, GA 30060
 (678) 797-8201

PATIENT INFORMATION

NAME (Last, First Middle)		SSN#	BIRTHDATE	SEX
LOCAL ADDRESS		SECONDARY/BILLING ADDRESS (if Applicable)		
CITY, STATE ZIP		CITY, STATE ZIP		
HOME PHONE		HOME PHONE		
PRIMARY EMPLOYER		SECONDARY EMPLOYER (if Applicable)		
ADDRESS		ADDRESS		
CITY, STATE ZIP		CITY, STATE ZIP		
WORK PHONE		WORK PHONE		

RESPONSIBLE PARTY INFORMATION (if Different than above)

NAME (Last, First Middle)		SSN#	BIRTHDATE	SEX
LOCAL ADDRESS		SECONDARY/BILLING ADDRESS (if Applicable)		
CITY, STATE ZIP		CITY, STATE ZIP		
HOME PHONE		HOME PHONE		
RELATIONSHIP TO PATIENT				

PRIMARY INSURANCE

NAME OF INSURANCE COMPANY		POLICY#		
NAME OF INSURED		GROUP#		
ADDRESS OF INSURANCE COMPANY		COPAY AMT \$		
CITY, STATE ZIP		DEDUCTIBLE \$		
RELATIONSHIP TO PATIENT		EFFECTIVE DATE	EXPIRATION DATE	

SECONDARY INSURANCE (if Applicable)

NAME OF INSURANCE COMPANY		POLICY#		
NAME OF INSURED		GROUP#		
ADDRESS OF INSURANCE COMPANY		COPAY AMT \$		
CITY, STATE ZIP		DEDUCTIBLE \$		
RELATIONSHIP TO PATIENT		EFFECTIVE DATE	EXPIRATION DATE	

I do hereby assign all medical benefits to which I am entitled, including all government and private insurance plans to this office. This assignment will remain in effect until revoked by me in writing. I understand that I am responsible for all my charges not paid by my insurance. I acknowledge that no assurance or promises have been given the patient concerning the results, which may be obtained by such treatments and procedures hereby, affirmed by the signature of the undersigned.

 SIGNATURE OF PATIENT/GUARDIAN

 DATE