Atlanta Cardiology Consultants, P.C.

Thomas S. Backer, M.D., F.A.C.C. / Katie Steffen, MMSC PA-C

PATIENT INFORMATION FORM

MARITAL STATUS
CIRCLCE ONE
S M D W

PATIENT NAME_______________________________________ BIRTHDATE________________________

ADDRESS____

HOME PHONE______________________WORK PHONE____________________SOCIAL SECURITY_________________________

EMPLOYER______________________________ADDRESS____

NAME OF SPOUSE____________________________________ ADDRESS_____________________________________

SPOUSE'S SOCIAL SECURITY #__________________________DOB__________________PHONE____________________

SPOUSE'S EMPLOYER AND ADDRESS ____

____ WORK PHONE_________________________

RELATIVE OR FRIEND WE CAN CONTACT IN CASE OF AN EMERGENCY:

NAME____ADDRESS____

HOME PHONE____ WORK PHONE_______________________________

I AUTHORIZE RELEASE OF MY MEDICAL RECORDS TO MY REFERRING PHYSICIAN

REFERRING PHYSICIAN____ X________________________________

NOTE: IF YOUR INSURANCE COMPANY REQUIRES A PRE-CERTIFICATION OR 2ND OPINION BEFORE ENTERING THE HOSPITAL, YOU MUST CONTACT YOUR REPRESENTATIVE TO MAKE ARRANGEMENTS. IF YOU DO NOT IT COULD MEAN THAT ALL OR A PORTION OF YOUR MEDICAL BILL WOULD NOT BE REIMBURSED TO YOU BY YOUR INSURANCE COMPANY. YOU MAY NEED ASSISTANCE FROM OUR OFFICE IN OBTAINING PRE-CERTIFICATION. LIST BELOW THE PRE-CERTIFICATION PHONE NUMBER PRINTED ON YOUR INSURANCE CARD.

PRIMARY INSURANCE-COMPANY NAME:____

ADDRESS:____

POLICY #____ GROUP #____________________________________

POLICY HOLDER NAME:_______________________________________ PRE-CERTIFICATION PHONE:__________________

IN ORDER TO KEEP OUR CHARGES AS LOW AS POSSIBLE, WE EXPECT PAYMENT AT TIME OF SERVICE, UNLESS OTHER ARRANGEMENTS ARE MADE

CHECK HOW YOU PLAN TO PAY TODAY: ☐ CASH ☐ CHECK ☐ CREDIT CARD

I acknowledge and agree that payment for services rendered is due at the time that such service is performed and acknowledge receiving and reading a copy of the Financial Policy. I authorize payment of benefits to Atlanta Cardiology Consultants, P.C. To release any medical or other information necessary to process insurance claims. I further authorize photocopies of this form to be as valid as the original.

X____ DATE:_________________________________

I authorize Atlanta Cardiology Consultants, P.C. To release my records for the purpose of treatment, payment, and healthcare operations.

X____ DATE:_________________________________