Metro
Atlanta
Gastroenterology
Metro Atlanta Endoscopy, LLC

PLEASE PRINT

Last Name: _____ **First**: _____ **MI**: _____

Address: _____
Number **Street** **Apt#**

_____
City **State** **Zip Code**

Home #: ( ) _____ Work #: ( ) _____ Cell #: ( ) _____

Birthdate _____ Sex:_____ Social Security # _____ Marital Status: _____ Race:_____

Reason for Visit / Chief Complaint: _____

Referring Physician/PCP/Internist: _____ Phone: ( ) _____

Address: _____ Fax: ( ) _____

Insurance Information:

{Primary Insurance}

Policy Holder: _____ Social Security #_____ Birthdate _____

Relationship: _____

Patient Employer:

Employer/Position: _____

Address: _____

City, State, Zip Code: _____

Spouse Information:

Name_____Birthdate_____ Social Security Number_____

Employer_____Work Phone_____Cell Phone_____

Emergency Contact:

Name: _____ Phone: _____ Relationship: _____

I authorize the release of any medical information, including information related to psychiatric care, drug and alcohol abuse and HIV/AIDs confidential information, necessary to process insurance claims or any medical information that is needed for any utilization review or quality assurance activities. I assign medical and/or surgical benefits to which I am entitled to the following physicians: Drs. Horney, McGahan, Carson, Weinstein, and Shapiro**. I understand I am fully responsible for all fees not covered by my insurance. In the event that my account is turned over to a collection agency, I understand and agree that I will be responsible for any collection fees (33.33%), reasonable attorney fees, court costs, etc.** This assignment will remain in effect until revoked by me in writing. A photocopy of this authorization shall be considered as effective and valid as the original. I have received a copy of Metro Atlanta Gastroenterology & Metro Atlanta Endoscopy practice policies covering appointments, after hours, prescription and insurance responsibilities.

Signed (Patient or Parent if Minor) **Date**