

**PATIENT INFORMATION**  
*Please complete each line of registration*

**Primary Doctor:**     • Gardiner     • Griffith     • Ellis     • Radman     • Culpepper  
 (Circle one)

Name: (Last) \_\_\_\_\_ (First) \_\_\_\_\_ (Middle) \_\_\_\_\_

Address: \_\_\_\_\_ (SSN) \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ Birth Date: \_\_\_\_\_

Phone: (\_\_\_\_) \_\_\_\_\_ Work: (\_\_\_\_) \_\_\_\_\_ Cell: (\_\_\_\_) \_\_\_\_\_ E-mail: \_\_\_\_\_

Sex: M F     Marital Status: Single     Married     Divorced     Widowed     Separated

Race: Black     Hispanic     Native American     Asian     Indian     White     Other \_\_\_\_\_

Patient's Employer Name: \_\_\_\_\_ Occupation: \_\_\_\_\_

Address: \_\_\_\_\_

Spouse or Parent's Name: \_\_\_\_\_ Employer: \_\_\_\_\_

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

<b>Insured (card holder/employee):</b>	Self	Spouse	Parent	Other
<b>Insured's Information:</b>				
Name(s): _____		Relationship: _____		
Date of Birth: ____/____/____		SSN: _____		Phone Number: (____) _____
Bus. Phone: (____) _____		Ext: _____	Cell Phone: (____) _____	
				Pager: (____) _____

**Insurance Coverage**

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

**Emergency Contact Information:**

Name: \_\_\_\_\_

Telephone: (\_\_\_\_) \_\_\_\_\_ Relationship: \_\_\_\_\_

Cell Phone: (\_\_\_\_) \_\_\_\_\_ Pager: (\_\_\_\_) \_\_\_\_\_

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. *Please note interest of 1½% per month will be charged on all balances that are 60 days past due, until paid in full.*

**Insurance Authorizations: Release of Information**

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.

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

*I give the providers of NCFP permission to treat my minor child.* **Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Notice of Privacy Practices received: Signature** \_\_\_\_\_ **Date** \_\_\_\_\_