COBBWEST INTERNAL MEDICINE
2713 Charles Hardy Pkwy, Ste 223
Dallas, GA 30157

PATIENT INFORMATION FORM

PLEASE PRINT

PATIENT

LAST NAME	FIRST NAME		MIDDLE	NAME CALLED		
STREET ADDRESS	APPT #	CITY	STATE	ZIP	MARITAL STATUS	
AREA CODE HOME PHONE	AREA CODE CELL PHONE	SOCIAL SECURITY #	SEX	DATE OF BIRTH	AGE	
EMPLOYED BY		SPOUSE'S NAME		EMPLOYED BY		
EMPLOYERS ADDRESS		EMPLOYERS ADDRESS				
OCCUPATION	BUS. PHONE & EX	OCCUPATION		BUS. PHONE & EX		
NEAREST FRIEND OR RELATIVE NOT LIVING WITH YOU		RELATIONSHIP TO INSURED (ALIAS)		PHONE		

POLICY HOLDER/INSURANCE INFORMATION

COPIES OF INSURANCE CARD REQUIRED

PRIMARY

LAST NAME	FIRST NAME	MIDDLE	RELATIONSHIP TO PATIENT		
STREET ADDRESS	APPT #	CITY	STATE	ZIP	
DATE OF BIRTH	SOCIAL SECURITY #			HOME PHONE	
EMPLOYED BY		BUS. PHONE			

Insurance Co. Name _____
Mailing Address _____ City, State, Zip _____
(A/C) Phone # ( ) _____-_____ ( ) _____-_____
Policy/Contract # _____ _____

SECONDARY

LAST NAME	FIRST NAME	MIDDLE	RELATIONSHIP TO INSURED (ALIAS)		
STREET ADDRESS	APPT #	CITY	STATE	ZIP	
DATE OF BIRTH	SOCIAL SECURITY #			HOME PHONE	
EMPLOYED BY		BUS. PHONE			

Insurance Co. Name _____
Mailing Address _____ City, State, Zip _____
(A/C) Phone # ( ) _____-_____ ( ) _____-_____
Policy/Contract # _____ _____

REFERRING INFORMATION

REFERRAL SOURCE _____

RECEIPT OF NOTICE OF PRIVACY PRACTICES **(Turn Over)**
This is to acknowledge that I have received a copy of (Cobbwest Internal Medicine Associates) Notice of Privacy Practices.

Date:_____ **Signature:**_____ **Relationship to Patient:**_____

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I REQUEST THAT PAYMENT OF AUTHORIZED benefits be made to
I authorize any holder of medical information about me to release to the Centers for Medicare and Medicaid Services and its agents any information needed to determine these benefits or the benefits payable to related services.

DATE _____ **Signature** _____

I hereby 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 required for any health care related utilization review or quality assurance activities or any healthcare professional requiring this information.

I hereby assign and authorize payment to of all medical and/or surgical benefits, including major medical policies, to which I am entitled to under any insurance policy or policies, under any self-insurance program, or under any benefit plan.

I understand and acknowledge that this assignment of benefits does not relieve me of my financial responsibility for all medical fees and charges incurred by me or anyone on my behalf and I hereby accept such responsibility, including, but not limited to, payment of those feesand charges not directly reimbursed to by any insurance policy, self-insurance program or other benefit plan.

This authorization shall 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 understand that I have the right to receive a copy of this authorization.

PERSON PROVIDING THE AUTHORIZATION _____

RELATIONSHIP TO PATIENT IF NOT PATIENT _____

Date _____

ALTERNATIVE CONTACT AUTHORIZATION

I ☐ DO ☐ DO NOT authorize you to contact or leave messages at my place of work.

Date: _____ Signature: _____

I ☐ DO ☐ DO NOT authorize you to contact me at my e-mail address.
(e-mail address if authorized _____)

Date: _____ Signature: _____

I hereby authorize you to leave messages on my home answering machine regarding appointments and to inform me that laboratory results are **available**. The laboratory **results** are NEVER left on the answering machine. You have to call the office to get them.

Date: _____ Signature: _____