PATIENT INFORMATION

Name: _____ Gender: __ Male __ Female Social Security #: _____
(First, Middle Initial, Last)

Address: _____ Date of Birth: _____ Age: _____
(Street)

_____ Marital Status: __ Married __ Single __ Widowed __ Divorced
(City, State, ZIP)

Home Phone: (_____) _____-_____ Race: __ White __ Black __ Hispanic __ Other
Cell Phone: (_____) _____-_____ Ethnicity: __ Non-Hispanic or Latino __ Hispanic or Latino
Work Phone: (_____) _____-_____ __ Other or Undetermined
Email: _____ Preferred Pharmacy: _____
Preferred Method of Contact: Preferred Pharmacy Phone Number: (_____) _____-_____
__ Home Phone __ Cell Phone __ Email __Work Phone Emergency Contact: _____
__ Letter Emergency Contact Phone #: (_____) _____-_____
Referring Physician: _____ Relationship to Emergency Contact: _____

PATIENT'S EMPLOYMENT INFORMATION __ Employed __ Retired __ Student __ Other

Employer / School: _____ Employer / School Phone #: (_____) _____-_____
Employer / School Address: _____ City, State, and ZIP: _____

GUARANTOR INFORMATION __ Same as Patient Relationship to Patient: _____

Name: _____ Employer: _____
Address: _____
City, State, & ZIP: _____ Guarantor Phone #: (_____) _____-_____
Date of Birth: _____ __ Home __ Work __ Cell

PRIMARY INSURANCE INFORMATION

__ Health __ Liability __ Other _____
Insured Party: _____
Insured Phone #: (_____) _____-_____
Relationship to Patient: _____
Insured's SS #: _____
Insured's Date of Birth: _____
Insured's Employer: _____
Insurance Company: _____
Insured's ID #: _____
Policy Group #: _____

SECONDARY INSURANCE INFORMATION

__ Health __ Liability __ Other _____
Insured Party: _____
Insured Phone #: (_____) _____-_____
Relationship to Patient: _____
Insured's SS #: _____
Insured's Date of Birth: _____
Insured's Employer: _____
Insurance Company: _____
Insured's ID #: _____
Policy Group #: _____

I authorize Albany Internal Medicine and Privia Medical Group Georgia to perform treatment deemed by the physician in exercise of professional judgment to be of appropriate kind and method on me or my dependent. I hereby authorize Albany Internal Medicine and Privia Medical Group Georgia to release any information acquired in my examination or treatment to any insurer, government agency providing benefits, or to anyone for billed charges.

SIGNED: _____ DATE: _____

I hereby assign to and authorize payment to Albany Internal Medicine and Privia Medical Group Georgia all benefits payable under the terms of any insurance policy listed above. I realize the insurance, workers compensation, and or liability claims may not pay the entire bill. I agree to pay the difference or the entire bill if necessary. I agree to allow Albany Internal Medicine and Privia Medical Group Georgia, or its agent, to call me directly to my home phone, cell phone, or employment phone number. I also agree to pay costs of collection, including attorney's fees and waive my exemption under the laws of the State of Georgia.

SIGNED: _____ DATE: _____