PATIENT INFORMATION SLIP

AMIGS, LLC
105 Collier Rd., Ste 1010
Atlanta, GA 30309

DATE_____

PLEASE PRINT CLEARLY ***TO BE COMPLETED BY PATIENT***

( ) Single ( ) Married ( ) Widowed ( ) Partnered ( ) Divorced Race_____

PATIENT NAME_____ DATE OF BIRTH_____

MAILING
ADDRESS_____ SOCIAL SECURITY NUMBER_____

CITY_____ STATE_____ ZIP_____ BUSINESS PHONE_____

HOME PHONE_____ CELL PHONE_____

EMAIL ADDRESS_____ HOW DID YOU HEAR ABOUT US?_____

EMPLOYED BY_____ OCCUPATION_____

SPOUSE/PARTNER'S NAME_____

SPOUSE/PARTNER'S PHONE NUMBER_____

EMPLOYER_____ OCCUPATION_____

RELATIVE TO CALL IN CASE OF EMERGENCY_____ RELATIONSHIP_____

ADDRESS_____ PHONE NUMBER_____

GIVE NAME OF ANOTHER LOCAL RELATIVE_____ RELATIONSHIP_____

ADDRESS_____ PHONE NUMBER_____

WHO IS RESPONSIBLE PARTY?_____ RELATIONSHIP_____

ADDRESS_____ PHONE NUMBER_____

EMPLOYER OF RESPONSIBLE PARTY_____

ADDRESS_____ PHONE NUMBER_____

NAME OF INSURANCE COMPANY_____ NAME OF POLICY HOLDER_____

NAME OF INSURED_____ SS#_____ POLICY NUMBER_____

NAME OF INSURANCE COMPANY_____ NAME OF POLICY HOLDER_____

NAME OF INSURED_____ SS#_____ POLICY NUMBER_____

NAME OF INSURANCE COMPANY_____ NAME OF POLICY HOLDER_____

NAME OF INSURED_____ SS#_____ POLICY NUMBER_____

MEDICARE NUMBER *_____ MEDICAID NUMBER *_____

**PLEASE PROVIDE CARD FOR RECEPTIONIST TO MAKE COPY BEFORE LEAVING OFFICE*

I AUTHORIZE THE RELEASE OF ANY INFORMATION NECESSARY TO PROCESS INSURANCE. I AUTHORIZE PAYMENT OF BENEFITS TO BE PAID DIRECTLY TO AMGIS, LLC. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR CHARGES NOT PAID BY INSURANCE.

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Signature of Patient or Authorized Person

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