



Name _____ Hm Phone _____ Cell or Wk Phone _____

Address _____

City _____ State _____ Zip _____ County _____

SS# _____ D.O.B. _____ Employed By _____

Email Address _____

SPOUSE

Name _____ SS# _____ D.O.B. _____

Employed By _____ Wk Phone _____

Complete if under 18 years old or a student

Name of Father _____ Employer _____ Wk Phone _____

SS# _____ D.O.B. _____

Name of Mother _____ Employer _____ Wk Phone _____

SS# _____ D.O.B. _____

Whom do we notify in an emergency? (Not residing with you)

Name _____ Relationship _____

Hm Phone _____ Wk Phone _____

INSURANCE INFORMATION

- Medicare
- Medicaid
- Blue Cross/Blue Shield VIP PPO GA AL
- State Merit
- Workers Compensation (job injury) Employer _____
- Aetna
- Other Medical Insurance Company _____

Authorization to release information:

I hereby authorize the above doctors to release any information required to process my medical claims. I permit a copy of this authorization to be used in place of the original and request payment of benefits to myself or the party who accepts assignment. Regulations pertaining to Medicare assignment of benefits apply.

Signature _____ Date _____