

Northeast Georgia Podiatry, P.C.

Patient Name:	Middle Initial:	Last Name:
Date of Birth:	Age:	Male/Female:
Address:	City	
State:	Zip:	Email Address:
Preferred Phone #: C/H/W	Other Phone #: C/H/W	Pharmacy Name & number:
Occupation:	Work #:	
Primary Care Physician Name:	Last Appt with this doctor:	PCP Phone number:
Spouse's name/ Parent or Guardian Name if Minor:		

Medical Insurance Information

Primary Insurance:		
Primary Policy Holder's Name		
Primary Policy Holder's Date of Birth:	Relationship to Patient:	
Policy holder's Address:		
Policy holder's Phone #:	Employer Name:	
Member ID#:	Group ID#	SS#:

Secondary Insurance:		
Primary Policy Holder's Name		
Primary Policy Holder's Date of Birth:	Relationship to Patient:	
Policy holder's Address:		
Policy holder's Phone #:	Employer Name:	
Member ID#:	Group ID#	SS#:

Emergency Contact Information

Person to Notify In case of Emergency:	Relationship to Patient:	
Home #:	Cell#:	Work #:

Referred by:

I understand that the above information is correct to the best of my knowledge. I also understand that it is my responsibility to inform Northeast Georgia Podiatry P.C. of any changes to my medial status. I hereby consent and authorize Northeast Georgia Podiatry P.C. and staff to perform any service deemed appropriate by attending physician(s) to make a thorough diagnosis. I also authorize Northeast Georgia P.C. and staff to perform any procedures, forms of treatments, mediation and therapy in connection with my diagnosis and treatment plan. I understand that payment for services, procedures and treatment forms is solely and ultimately my responsibility. I understand that payment services is due at the time that services are rendered, unless other financial arrangements have been made. There will be a \$25 fee for returned checks.

I hereby authorize and request that all payments be made directly to Northeast Georgia Podiatry, P.C. for Medical or Surgical Services rendered at Northeast Georgia Podiatry, P.C.

Signature: _____ Date: _____

Print Name: _____