Oakwood Family Care

4205 Mundy Mill Place
Oakwood, GA 30566
Tel: 770-287-1140 Fax: 770-534-2700

E-Mail: _________________ Home Phone: _____________ Cell: _________________

PATIENT INFORMATION

Name: ________________________________ Soc. Sec. #______________________

Address____

City_________________________ State________ Zip code_____________________

Male/Female Age______ DOB__________________ Marital Status _____________

Patient Employed by __________________________ Occupation ________________

Business Address ____

Business Phone # ____________________ Are you a Student? ___________________

Whom may we thank for referring you? ______________________________________

In Case of an emergency who should be notified? ______________________________

Emergency phone number? ____

PRIMARY INSURANCE

Person Responsible for account ____
Relation to Patient ______________ DOB ___________ Soc. Sec # _______________
Address ____
City ___________________ State _______ Zip ___________ Phone ______________
Insurance Company ____
Member ID # _________________________ Group #___________________________

SECONDARY INSURANCE

Is patient covered by additional insurance? YES _______ NO ______
Insurance Company ____
Member ID # _________________________ Group #___________________________

ASSIGNMENT and RELEASE

I, the undersigned certify and I (or my dependent) have insurance with ____________________ and assign directly to Dr. Yazdi all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance; I hereby authorize Oakwood Family Care to release all information necessary to secure payment of benefits. I authorize the use of this signature on all insurance submissions.

____________________________ ____________________________ _____________

Responsible Party Signature Relationship Date