INFECTIOUS DISEASES ASSOCIATES, P.C.

(770) 991-1500

PATIENT'S NAME: ___________________________________MALE___ FEMALE___

D.O.B.: __________________ SOCIAL SECURITY#:____________________________

STREET ADDRESS:

____

STATE: _____________ ZIP CODE: _________ HOME PHONE: ________________

WORK PHONE: _____________ EXT.______ CELL PHONE: ________________

PREFERRED CONTACT NUMBER (PLEASE CHECK ONE) CELL___ HOME ___ WORK ___

EMPLOYER'S NAME: ____

EMPLOYER'S ADDRESS: ____

SPOUSE'S NAME: ________________________________ D.O.B.: _______________

SOCIAL SECURITY #: ____________________ CONTACT NUMBER: ___________

IN CASE OF AN EMERGENCY (OTHER THAN SPOUSE):

PLEASE CONTACT: ____________________ PHONE NUMBER: _________________

RELATIONSHIP: _______________________

PRIMARY INSURANCE COMPANY: ________________ PHONE #: _______________

ID #: _____________GROUP #: _____________ SUBSCRIBER NAME: ____________

POLICY HOLDER: __________________ D.O.B: ________ SSN: _________________

RELATION TO PATIENT: ____________________ ID #: ________________________

I authorize Infectious Diseases Associates, P.C. to release to my insurance company, any information required in the course of my examination or treatment. I also authorize any physician, hospital or clinic to provide details of my medical history to Infectious Diseases Associates. P.C.

______________________________________ _____________

Signature of Patient Date

______________________________________ _____________

Printed Name of Patient Date