Metro Atlanta Gastroenterology
Metro Atlanta Endoscopy, LLC

PLEASE PRINT

Last Name: _____ **First**: _____ **MI**: _____

Address: _____
Street city zip code

Home phone #: _____ Cell phone #: _____ email_____

Birthdate _____ Sex: _____ Marital Status: _____ Race_____ Ethnicity_____ Language_____

Preferred method of contact (check one) Phone _____ E-mail _____ Postal mail _____

Reason for Visit / Chief Complaint: _____

Referring Physician/PCP/Internist: _____ Phone: ( ) _____

Address: _____ Fax: ( ) _____

Insurance Information:

{Primary Insurance} Last Four Digits

Policy Holder: _____ Social Security #_____ Birthdate _____
Relationship: _____

Patient Employer:

Employer/Position: _____

Address: _____

City, State, Zip Code: _____

Spouse Information:

Name_____ Birthdate_____

Employer_____Work Phone_____Cell Phone_____

Emergency Contact:

Name: _____ Phone: _____ Relationship: _____

I authorize the release of any medical information, including information related to psychiatric care, drug and alcohol abuse and HIV/AIDs confidential information, necessary to process insurance claims or any medical information that is needed for any utilization review or quality assurance activities. I assign medical and/or surgical benefits to which I am entitled to the following physicians: Drs. Horney, McGahan, Carson, Weinstein, Shapiro, and Curtis**. I understand I am fully responsible for all fees not covered by my insurance. In the event that my account is turned over to a collection agency, I understand and agree that I will be responsible for any collection fees (33.33%), reasonable attorney fees, court costs, etc.** This assignment will remain in effect until revoked by me in writing. A photocopy of this authorization shall be considered as effective and valid as the original. I have received a copy of Metro Atlanta Gastroenterology & Metro Atlanta Endoscopy practice policies covering appointments, after hours, prescription and insurance responsibilities.

Signed (Patient or Parent if Minor) **Date**

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