SPECTRUM INTERNAL MEDICINE

401 South Main Street, Suite C7, Alpharetta, GA 30009. Tel.: 678-319-9901, Fax: 678-319-9902

Patient Registration

Personal Information (please print)

Today's Date: _______________

Last Name:____________________ First Name _________________ Middle Name__________________

Address:____ City/State: ______________________

Zip Code _______________________ Email Address:________________@_________________

Sex: M __ F __ Date of Birth: _____________ Age: ______ Social Security # _______________________

Home Phone: ____________________________ Cell Phone ____________________________

Marital Status: Single ______ Married ______ Divorced ______ Widowed ______ Military: (Active/Inactive)

Employed (Y/N), Full-time ______ Part-time ______ Work Type:___________________ Student: Yes/No

Employer: ____Phone: ___________________

Employer's Address: _____________________________________

Pharmacy name & Phone #: ____

Referred By: ____

Spouse's Name_____________________________________ Address________________________________

Cell Phone #____________________ Work Tel. #_______________ Email______________@___________

Emergency Contact

Name:_______________________________________ Email Address________________@____________

Home Address: ____ Relationship: _____________________

Home Phone: _________________ Cell Phone: ___________________

Insurance Information

Primary Insurance Co: ____

Policy ID # ____ Group # _____________________________

Policyholder Name ____

Social Security # _____________________________________ Date of Birth __________________________

Relationship to Patient: Self ______ Spouse ______ Parent ______ Other ______

Secondary Insurance Co: ____

Policy ID # ____ Group # ______________________________

Policyholder Name ____ (continue on Page 2)

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Social Security # ____Date of Birth _____________________________

Relationship to Patient: Self ______ Spouse ______ Parent ______ Other ______

Financial Policy

Our office accepts all major credit cards, as well as cash or check for your convenience. All co-pays are the patient's responsibility and are due at time of service. A $25:00 dollar fee will be accessed on all returned checks and the patient or Guarantor will be held responsible for payment and you may not be seen for treatment until it is paid off. All outstanding balances are due within 30 days unless prior arrangements have been made with the Billing Department. All balances that reach 90 days past due will be sent to a collection agency. Should your account be sent to a collection agency, you will be financially responsible for all collection fees and legal fees that our office incurs through the process utilized to collect the outstanding delinquent balance. It is important for you to understand that your health insurance coverage is an agreement between you and your insurance company. Your doctor's bill for services provided to you is an agreement between you and your doctor.

I authorize release of any necessary medical information to determine benefits or the benefits payable for related services. I have read and fully understand the Financial Policy set forth by Spectrum Internal Medicine and agree to the terms of the Financial Policy.

_______________________________	____________	_________________________
Signature of Patient or Guardian	**Date**	**Print Name**

Updated 05/2014