

# GWINNETT CLINIC

PLEASE PRINT

NEW PATIENT REGISTRATION

RESPONSIBLE PARTY INFORMATION							
LAST NAME		FIRST	M.I.	MARITAL STATUS <input type="checkbox"/> M <input type="checkbox"/> S <input type="checkbox"/> W	HOME PHONE ( ) - ( ) - ( )	WORK PHONE ( ) - ( ) - ( )	CELL PHONE ( ) - ( ) - ( )
ADDRESS							
CITY	INDICATE NO. OF INS. PLANS	DEPENDENTS	STATE	ZIP CODE	SEX	AGE	DATE OF BIRTH / /
SOCIAL SECURITY NO.				IS RESPONSIBLE PARTY THE PATIENT? <input type="checkbox"/> YES <input type="checkbox"/> NO		HAS RESPONSIBLE PARTY BEEN A PATIENT? <input type="checkbox"/> YES <input type="checkbox"/> NO	
EMPLOYED BY	YEARS	ADDRESS	CITY	STATE	ZIP CODE	TELEPHONE ( ) - ( ) - ( )	

REFERRED BY - <input type="checkbox"/> CHECK HERE IF REFERRED BY DOCTOR					
LAST NAME		FIRST	M.I.	ADDRESS	TELEPHONE ( ) - ( ) - ( )

IN CASE OF EMERGENCY NOTIFY					
LAST NAME		FIRST	M.I.	ADDRESS	TELEPHONE ( ) - ( ) - ( )

DEPENDENT INFORMATION - DO NOT COMPLETE IF RESPONSIBLE PARTY IS THE PATIENT															
SPOUSE OR DEPENDENTS LAST NAME (IF DIFFERENT)			FIRST NAME		M.I.	2ND DEPENDENTS LAST NAME (IF DIFFERENT)			FIRST NAME		M.I.				
DATE OF BIRTH / /	SEX	RELATIONSHIP	SOCIAL SECURITY NO.		IS THIS DEPENDENT THE PATIENT? <input type="checkbox"/> YES <input type="checkbox"/> NO		DATE OF BIRTH / /	SEX	RELATIONSHIP	SOCIAL SECURITY NO.		IS THIS DEPENDENT THE PATIENT? <input type="checkbox"/> YES <input type="checkbox"/> NO			
EMPLOYED BY OR SCHOOL				TELEPHONE ( ) - ( ) - ( )				EMPLOYED BY OR SCHOOL				TELEPHONE ( ) - ( ) - ( )			
ADDRESS OF EMPLOYER OR SCHOOL						ADDRESS OF EMPLOYER OR SCHOOL									

INSURANCE COMPANY INFORMATION															
NAME OF PRIMARY INSURANCE COMPANY				GROUP NO.				NAME OF SECONDARY INSURANCE COMPANY				GROUP NO.			
ADDRESS								ADDRESS							
CITY	STATE	ZIP CODE	TELEPHONE ( ) - ( ) - ( )				CITY	STATE	ZIP CODE	TELEPHONE ( ) - ( ) - ( )					
NAME & ADDRESS OF INSURED IF THE RESPONSIBLE PARTY IS NOT THE INSURED															

REASON FOR TODAY'S VISIT - OR - CHIEF COMPLAINT:
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I AUTHORIZE GWINNETT CLINIC LTD. & THEIR PHYSICIANS TO EXAMINE, EVALUATE AND TREAT \_\_\_\_\_ (NAME OF PATIENT) FOR PRESENT AND ANY FUTURE PROBLEMS FOR WHICH SAME PATIENT COMES BACK FOR EXAMINATION, EVALUATION AND TREATMENT. I UNDERSTAND THAT THE OFFICE DOES NOT BILL FOR ROUTINE OFFICE CHARGES AND THAT PAYMENT IS DUE AT THE TIME OF SERVICE UNLESS OTHERWISE APPROVED BY OFFICE STAFF. I ALSO AUTHORIZE RELEASING INFORMATION TO MY REFERRING PHYSICIAN/CLINIC AND MY EMPLOYER (IF WORKMAN'S COMPENSATION INJURY).

**PAYMENT AGREEMENT**

I UNDERSTAND THAT, AS A COURTESY GWINNETT CLINIC LTD. MAY FILE MY CLAIMS TO THE APPROPRIATE INSURANCE COMPANY. HOWEVER, ALTHOUGH INSURANCE FORMS WILL BE SUBMITTED, ALL CHARGES ARE PRIMARILY MY RESPONSIBILITY.

IF MY INSURANCE PAYMENT IS NOT RECEIVED WITHIN 60 DAYS FROM THE DATE OF SERVICE/TREATMENT, I AGREE TO PAY THE ENTIRE AMOUNT OF THE BALANCE DUE, UNLESS MY INSURANCE COMPANY HAS A CONTRACTUAL AGREEMENT WITH GWINNETT CLINIC LTD. & THEIR PHYSICIANS.

I ALSO AGREE TO PAY INTEREST AT THE RATE OF 1.5% PER MONTH IF MY BILL IS NOT PAID WITHIN 90 DAYS OF DATE OF SERVICE/TREATMENT.

DUE TO DEFAULT, I ALSO AGREE TO PAY ALL COST OF COLLECTION, INCLUDING, BUT NOT LIMITED TO, COURT COSTS, COLLECTION AGENCY FEES, ATTORNEY FEES, ETC.

DATE \_\_\_\_\_ AUTHORIZED PERSON'S SIGNATURE: \_\_\_\_\_ RELATIONSHIP TO PATIENT: \_\_\_\_\_

PAYMENT OF BENEFITS	
I AUTHORIZE PAYMENT OF BENEFITS, AS DETERMINED BY THE COMPANY, DIRECTLY TO:  GWINNETT CLINIC LTD.	
I ALSO UNDERSTAND THAT I MAY STILL BE RESPONSIBLE FOR ANY AMOUNTS NOT PAID BY MY INSURANCE COMPANY	
X	DATE / /

MEDICAL RELEASE AUTHORIZATION	
INSURED PARTY MUST SIGN FOR ALL CLAIMS. DEPENDENT PATIENT MUST ALSO SIGN IF NOT A MINOR. I AUTHORIZE ANY INSURANCE COMPANY, ORGANIZATION, EMPLOYER, HOSPITAL, PHYSICIAN, DENTIST, OR PHARMACIST TO RELEASE ANY INFORMATION REQUESTED WITH REGARD TO PROCESSING MY CLAIM. I CERTIFY THAT THE INFORMATION I FURNISH IS TRUE AND CORRECT. I KNOW IT IS A CRIME TO FILL OUT THIS FORM WITH FACTS I KNOW ARE FALSE OR TO LEAVE OUT FACTS I KNOW ARE IMPORTANT.	
X	DATE / /
X	DATE / /