FAMILY CARE
DAHLONEGA

NEW PATIENT DEMOGRAPHIC/INSURANCE

Full legal name:_____
Mailing Address:_____ City:_____
Zip:_____
DOB:_____ Gender at birth:_____
Marital status:__ S __M__D__W
SSN:_____ Preferred language:_____
Home phone:_____ Cell phone: _____
Employer: _____ (list Parent's if minor)
Responsible Party for visit:_____ (list Parent if minor)
Primary Insured Name:_____ DOB: _____
Race:__ White __ Asian __ American Indian or Native __Black or African American __ Native Hawaiian or other Pacific Islander

Emergency contact name: _____ Relationship:_____
Address:_____ City:_____
Zip:_____ Phone: _____

Primary Doctor Name: _____ OR __ use this office

Primary Insurance Carrier Name:_____
Secondary Insurance Carrier Name:_____

Notice: Insurance is considered a method of reimbursing the patient for fees paid to the office and is not substitute for payment. Some companies allow fixed allowances for certain procedures and others pay a percentage of the charges. It is your responsibility to pay any deductible, co-insurance, or other balance not paid by your insurance. It is required that all charges for each visit are paid at the conclusion of each visit.

By signing this you expressly consent and agree that in order to discuss or service your account(s) (the "Accounts") or to collect accounts you may owe, Family Care Dahlonega, and it's officers/agent/affiliate/employee or any affiliated service provider and third-party debt collection agency associated therewith (collectively, "We") may contact you by telephone at

any number associated with the account, includes wireless telephone numbers, which could result in charges to you. You expressly consent and agree that We may also contact you by sending text messages, emails, using any email address you may provide to us, or by pre-recorded or artificial voice or voice messages, automatic dialing methods, systems, or devices, and pre-recorded or artificial voice prompts at any telephone number associated with the Accounts, including wireless or mobile telephone numbers, regardless of whether you incur charges as a result.

I authorize the release of any medical information necessary to determine liability for payment and to obtain reimbursement on any claim. I request that payment of authorized benefits be made on my behalf. I assign the benefits payable for all medical or surgical benefits to include major medical benefits which I am entitled including Medicare, private insurance, and other agency reimbursements to Family Care Dahlonega. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges whether paid or not by said insurance. I hereby authorize said assignee to release all information necessary to secure payment.

In the case that I do not have insurance, my insurance company denies or only partially pays the claim, I understand that I am fully responsible for any unpaid balance.

Patient/authorized party signature: _____

Date:_____