***Atlanta ID Group***
***Patient Information Form***

Today's Date________________

**MEDICAL INSURANCE INFORMATION (Please submit your card(s) and photo identification to be copied.)**

Name: ________________________________ _______ _______________________________ Date of Birth: _____________________
*(First)* *(MI)* *(Last)*

Sex: ○ Male ○ Female SS#: ________________________

Address: ________________________________________________________________________ Apt/Ste#: __________________

City: _______________________________________________________ State: ________________ Zip: _____________________

Home Phone: ______________________ Cell Phone: _________________________ Work Phone: ________________________

Marital Status: ○ Married ○ Single ○ Divorced ○ Widowed

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Employment Status: __________ Employer Name: _______________________________ Student: ○**FT** ○**PT** ○**NA**

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Pharmacy Name: _________________________________ Pharmacy Phone #: ____________________________

Location/Address: _________________________________ Fax #_______________________________________

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EMERGENCY CONTACT INFORMATION: Individual to contact in an emergency. This information is needed in case we need to reach you after your visit and we are unable to reach you directly.

_______________________________ __________________________________ ______________________________
*(First)* *(Last)* *(Relation Ship to Patient)*

Home Phone: ___________________ Cell Phone: ___________________ Work Phone: ____________________

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**ADULT ACCOMPANYING MINOR PATIENT Only for patients under 18 years of age.**

_______________________________ __________________________________ ______________________________
*(First)* *(Last)* *(Relation Ship to Patient)*

SS#: ______________________________ Date of Birth: __________________________

Home Phone: _________________ Cell Phone: __________________ Work Phone: ___________________

Employment Status: ________ Employer Name: ______________________________ Student: ○**FT** ○**PT** ○**NA**

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**Insurance Information:**

**Primary**_______________________________ **Member ID#:**_____________________________ **Group:** ______________________

**Secondary:** ___________________________ **Member ID#:**_____________________________ **Group:** ______________________

**POLICY HOLDER INFORMATION Policy Holder is:**

○ **Same as Patient (skip this section)** ○ **Other (Complete this section)**

Name: _______________________________________ _______________________________ Relationship to Patient: _____________
*(First)* *(Last)*

Address: ___________________________________________________________________________ Apt/Ste#: __________________

City: ____________________________________ State: ___ Zip: _________ SS#: _________________ Date of Birth: ____________

Home Phone: ______________________ Cell Phone: _________________________ Work Phone: ________________________

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**HIPAA**: This is to acknowledge that I have read and received a copy of the privacy practices.

**Patient or Guardian Signature:** _________________________________________________ **Date:** __________________________

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Would you like to have communications sent to you via your e-mail address? ○**Yes** ○ **No**
(Examples: appointment reminders, administrative updates)

E-mail address: ______________________________________________________