

Surgical Associates of Atlanta, P.C.  
550 Peachtree Street N.E.  
Suite 1215  
Atlanta, Georgia 30308  
(404)688-1934

**PATIENT INFORMATION**

Date \_\_\_\_\_ Soc. Sec. # \_\_\_\_\_ Birthday \_\_\_\_\_ Age \_\_\_\_\_

Name \_\_\_\_\_  
Last Name First Name Initial

E-Mail \_\_\_\_\_ Phone Number \_\_\_\_\_

Address \_\_\_\_\_ Cell \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Sex \_\_\_\_\_ Single Married Divorced Widowed

Height \_\_\_\_\_ (FT) \_\_\_\_\_ (IN) Weight \_\_\_\_\_

Employer \_\_\_\_\_ Business Phone \_\_\_\_\_

Business Address \_\_\_\_\_ Occupation \_\_\_\_\_

Who should we thank for referring you? \_\_\_\_\_

In case of emergency, who should we contact? \_\_\_\_\_

**PRIMARY INSURANCE**

Person Responsible for Account \_\_\_\_\_  
Last Name First Name Initial

Relationship to Patient \_\_\_\_\_ Birthdate \_\_\_\_\_ Soc. Sec. # \_\_\_\_\_

Insurance Company \_\_\_\_\_

Subscriber I.D. # \_\_\_\_\_ Group # \_\_\_\_\_

**ADDITIONAL INSURANCE (IF APPLICABLE)**

Insured Name \_\_\_\_\_  
Last Name First Name Initial

Relationship to Patient \_\_\_\_\_ Birthdate \_\_\_\_\_ Soc. Sec. # \_\_\_\_\_

Address \_\_\_\_\_ Home Phone \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Insured Employed By \_\_\_\_\_ Insurance Company \_\_\_\_\_

Subscriber I.D. # \_\_\_\_\_ Group # \_\_\_\_\_

**ASSIGNMENT AND RELEASE:**

I hereby authorize payment directly to Surgical Associates of Atlanta for all insurance benefits otherwise payable to me for services rendered. I understand that I am financially responsible for all charges, whether or not paid by insurance, and for all services rendered on my behalf or dependents.

I authorize the above doctor and/or any provider or supplier of services in this office to release the information required to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

**Signature of Responsible Party:** \_\_\_\_\_