

Alliance Medical Center, P.C.
610 Peachtree Parkway
Suite 201
Cumming, GA 30041
(770) 888-2733

Date _____ E-Mail Address _____

Last Name _____ First Name _____ MI. _____

Street Address _____ Apt # _____ City _____

State _____ Zip _____ Sex: Male _____ Female _____ Birthdate _____ Age _____

Home # () _____ Cell Phone # () _____

Employer _____ Work # () _____ Ext # _____

Marital Status: S _____ M _____ W _____ D _____ Social Security # _____

IN CASE OF EMERGENCY, NEAREST RELATIVE/FRIEND NOT RESIDING AT SAME ADDRESS

Name _____ Telephone # () _____ Relationship _____

Address _____ Apt # _____ City _____ State _____ Zip _____

INSURANCE INFORMATION

Name of Insurance Company _____ S.S./ID # _____

Group # _____ Subscribers Name _____ Relationship to Patient _____

Employer _____ Subscribers D.O.B. _____

Secondary Insurance _____ S.S./ID# _____

Group # _____ Subscribers Name _____ Subscribers D.O.B. _____

ASSIGNMENT OF BENEFITS/RELEASE OF MEDICAL RECORDS-I authorize payments directly to the physician for all medical services rendered to me or my dependent as well as the release of any medical information necessary to process claims.

GUARANTEE OF ACCOUNT-For services furnished by Alliance Medical Center, P.C.. I hereby guarantee the payment of all accounts for services rendered to myself or dependent(s). I hereby waive all claims of exemption under the State of Georgia laws and agree to pay, if necessary, all costs of collection, including attorney fees.

Signature of Patient/Guardian

Date

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