Welcome to Piedmont Family Practice

Patient Information

Last _____ First _____ MI _____ Prev. _____

SSN: _____ DOB _____ Sex M or F

Billing Address

Street _____ Apt # _____

City _____ State _____ Zip _____

Physician _____ Marital Status _____

Home Phone _____ May we leave messages for you? Y or N

Work Phone _____ Alt. Work _____

Cell Phone _____ Alt. Cell _____

E-mail _____ May we contact you through E-mail? Y or N

Insurance Information

Policy Holder Name _____ Relationship _____

Plan Name _____

Plan Number _____ Policy Number _____

Group Name _____ Group Number _____

Address _____

City _____ State _____ Zip _____

Emergency Contact Information

Full Name _____ Relationship _____

Street _____ Phone _____

City _____ State _____ Zip _____

Can we discuss your medical records with this person? Y or N

Please list all people who you authorize us to discuss your medical records with (blank means no one)

_____

_____

_____

_____

(Please fill out other side)

Welcome to Piedmont Family Practice

Acknowledgment of Receipt of Privacy Notice

By signing this form I acknowledge that I have received, read, and understand Piedmont Family Practice's Notice of Privacy Practices

Signature (Patient or Authorized Representative) _____ Date _____

Acknowledgement of Receipt of Financial Policy

By signing this form I acknowledge that I have received, read, and understand Piedmont Family Practice's Financial Policy. I also understand that payment is expected when services are rendered, if my acount becomes delinquent and requires submission to outside collection, I agree to pay all collection costs, court costs, and attorney fees.

Signature (Patient or Authorized Representative) _____ Date _____

Insurance Coverage & Authorizations

I hereby authorize Piedmont Family Practice and its providers to apply for benefits on my behalf for covered services rendered. I certify that the information I have submitted is correct. I further authorize the release of any necessary information, including medical information, to my insurance carrier. In the case of Medicare Bart B benefits, to the Social Security Administration and Health Care Financing Administration. A copy of this authorization may be used in place of the original. This authorization may be revoked by either my insurance carrier or me at any time in writing.

Signature (Patient or Authorized Representative) _____ Date _____

office use only

Modification Record

Please date and initial below each time this document is updated
