

Greater Athens Physicians, Inc.

H. Philip Morris, Jr., M.D.

Athens, GA

PATIENT INFORMATION				
Last Name		First Name		Middle Initial Nick Name
Street Address		Apt, Lot # or PO Box		City, State, Zip
Sex M / F	Employer Name		address	Student Full time/Part Time
Home Phone		Work Phone	Ext	Cell Phone
Date Of Birth	Social Security Number	Marital Status	Race	Spouse's Name
Referred By		Relative or Friend not living with you		
Relative/Friend Address		Relative/Friend Phone		Relationship

INSURED PARTY INFORMATION				
Insured's Last Name		Insured's First Name		Insured's Middle Name
Sex M / F	Insured's Date of Birth	Insured's Home Address		City, State & Zip
Insured's Social Security #		Insured's Home Phone		Insured's Work Phone
Insured's Employer		Insured's Employer Address and Phone Number		

PRIMARY INSURANCE INFORMATION		
Please present your card/s to the receptionist so she may copy the card for your file. Thank you		
Insurance Company's Name	(HMO,PPO,POS,etc)	Attention To:
Insurance Address		City, State and Zip
Insurance Company's Phone Number	Insurance Group Name / Number	Effective Date of Insurance
Insurance Insured's ID #	Patient's Relationship to the Insured (Self, Spouse, Child, etc)	

SECONDARY INSURANCE INFORMATION		
Insurance Company's Name	Attention To:	
Insurance Address		City, State and Zip
Insurance Company's Phone Number	Insurance Group Name / Number	Effective Date of Insurance
Insurance Insured's ID #	Patient's Relationship to the Insured (Self, Spouse, Child, etc)	

Insurance Payment

All services rendered are charged to the patient. Necessary forms will be completed to help expedite insurance carrier payments. However, the patient is responsible for all fees, regardless of insurance coverage. Payment is due at the time of service.

<p>AUTHORIZATION TO PAY BENEFITS TO PHYSICIAN: I hereby authorize payment directly to the physician of the surgical and/or medical benefits, if any, otherwise payable to me for his/her services as described realizing that I am responsible to pay non-covered services.</p>	<p>Signature _____ Date _____</p>
<p>AUTHORIZATION TO RELEASE INFORMATION: I hereby authorize the physician to release any information required in the course of my treatment necessary to process insurance claims.</p>	<p>Signature _____ Date _____</p>