8.2-MTBC-F-10

CONFIDENTIAL

ATHENS RHEUMATOLOGY CLINIC

REGISTRATIONIN FORMATION

PLEASEPRINT

○ New Patient

○ Existing Patient

Existing Patient: Revise all information that has changed since your last visit

HOME PHONE: (_____) ______-_________

CELL PHONE: (_____) ______-_________

DATE ____/____/________ **EMAIL ADDRESS** ____

PATIENT'S NAME: ____ , ____ _____________

LAST *FIRST* *MI*

STREET ADDRESS: ____

CITY: ______________________________________ **STATE:** ________________ **ZIP:** ______________________________________

GENDER: ○ ***m -/F*** **BIRTH-DATE:** _____/_____/_______ ***SINGLE*** ○ ***MARRIED*** ***WIDOWED***

SSN: ______ - ______ - _______ **PREFERRED LANGUAGE**_______________________**ETHNICITY**_____________ **RACE** ________________

PATIENT EMPLOYED BY :____

OCCUPATION:____ **BUSINESS PHONE:** (_____) ______-_________

NAME OF SPOUSE / RESPONSIBLE PARTY (IF PATIENT IS MINOR):______________________ , _______________________ __________

LAST *FIRST* *MI*

SPOUSE / RESPONSIBLE PARTY EMPLOYED BY:____

OCCUPATION: ____ **BUSINESS PHONE:** (_____) ______-_________

RESPONSIBLE PARTY/SPOUSE SSN : ______ - ______ - _________

DO YOU HAVE MEDICAL INSURANCE ? ○ NO ○ YES

NAME OF PRI. INS. : ____ **ID #:** ________________________**GRP #:**______________________

***SUBSCRIBER'S NAME:** ____ ***BIRTH DATE:** ______/______/____________

ADDRESS OF PRI. INS. :____

NAME OF SEC. INS. :____ **ID #:** ________________________**GRP #:** _______________________

***SUBSCRIBER'S NAME:** ____ ***BIRTH DATE:**______/______/___________

ADDRESS OF SEC. INS. :____

IN CASE OF EMERGENCY, WHO SHOULD BE NOTIFIED?______________________________ RELATIONSHIP______________________________

PERSON AUTHORIZED TO RECEIVE PHI ____ RELATIONSHIP _____________________________

PHONE:(_____) ______-_________

ASSIGNMENTOFINSURANCEBENEFITS

I, the undersigned, hereby authorize the release of any information relating to all claims for benefits submitted on behalf of myself and/or dependents. I further expressly agree and acknowledge that my signature on this document authorizes my physician to submit claims for benefits, for services rendered or for services to be rendered, without obtaining my signature on each and every claim to be submitted for myself and/or dependents, and that I will be bound by this signature as though the undersigned had personally signed the particular claim.

I, ____hereby authorize____

(NAME OF INSURED) **(NAME OF INSURANCE COMPANY)**

to pay and hereby assign directly to **SANA MAKHDUMI,MD,** all benefits, if any, otherwise payable to **(PROVIDER'S NAME)**

me for his/her services as described on the attached forms. I understand I am financially responsible for charges incurred. I further acknowledge that any insurance benefits, when received by and paid to **SANA MAKHDUMI, MD** **(PROVIDER'S NAME)**

will be credited to my account, in accordance with the above said assignment.

_______________________________________ _______________________

(AUTHORIZED SIGNATURE OF SUBSCRIBER) **(DATE)**