Gwinnett Consultants in Cardiology
Patient Registration
PLEASE PRINT

PATIENT INFORMATION

Mr. ☐ Mrs. ☐ Ms. ☐ _____ **SSN:** _____
Last Name First MI

Address: _____
City State Zip

Home #: (_____) _____ **Birth Date:** _____ /_____ /_____

Cell #: (_____) _____ **Marital Status (**circle one**): S M D W SEP**

Email: _____ **Sex: Male ☐ Female ☐**

Referring Physician: _____ **Phone: (_____)** _____

Primary Care Physician: _____ **Phone: (_____)** _____

EMPLOYMENT INFORMATION

Employer: _____

Address: _____ _____ _____
City State Zip

Employer Phone: _____

INSURANCE INFORMATION

We gladly file your insurance claims for you. However, the patient or guarantor is still responsible for all fees regardless of insurance coverage.

Primary: _____

Secondary: _____

Other: _____

We must have copies of any insurance cards before we can file your insurance.

INSURED INFORMATION

Person responsible for payment (if not the patient): _____ **Birth Date:** _____ /_____ /_____

Insured's employer: _____ **SSN:** _____

Relationship of PATIENT to INSURED (circle one): Self Spouse Child Other _____

EMERGENCY CONTACT INFORMATION

Name: _____ Contact #: _____

Insurance Authority and Assignment/Information Release:

I, the undersigned, hereby authorize payment directly to Gwinnett Consultants in Cardiology and treating physicians of the insurance benefits otherwise payable or due to become payable. I understand and agree that I am financially responsible for any charges not covered by this assignment of insurance benefits. Also, I hereby assign Gwinnett Consultants in Cardiology, my rights under Georgia Law to have any insurance claim processed and/or paid within 15 working days of the receipt of the claim by the insurance company. It is further agreed that any credit balance resulting from insurance payments or other sources that are refundable to the responsible party will be applied to any other account owed to Gwinnett Consultants in Cardiology by my family or myself.

If any amount due under this account is not paid, and at the sole discretion of GCC is referred to an outside collection source, I acknowledge responsibility for and agree to pay all costs of collection, including reasonable attorney fees, whether or not a lawsuit is commenced as part of the collection process. I further understand that GCC may apply finance charges to outstanding balances as provided by law and I agree to pay such charges if incurred.

_____ _____
Patient Signature Date