North Atlanta Endocrinology and Diabetes, P.C.
Patient Information Sheet

Demographic Information

Patient ID #: _____

First Name: _____ **Middle:** _____ **Last Name:** _____

Prefix: _____ **Suffix:** _____ **Nickname:** _____ **Maiden Name:** _____

DOB: _____ **Age:** _____ **Sex:** _____ **SSN:** _____

Marital Status: _____ **Employer:** _____

Race: Please Circle

Federal regulations now require that we collect the following demographic information below

American/Indian/Alaska | Asian | White

Black/African American | Nat Hawaiian/Pacific Islander | Other Race

Are you of Hispanic/ Latino descent? **YES / NO**

Contact Information

Mailing Address: _____ City: _____ State: _____ ZIP: _____

Phone numbers (Please check the box next to the best number to reach you)

Home: ☐ _____ **Work:** ☐ _____ **Cell:** ☐ _____

Email: _____

Primary Care/Family Doctor: _____ **Referring Doctor:** _____

Preferred Pharmacy (Name, City, & Street:) **Mail Order Pharmacy:** _____

_____

_____

Emergency Contact: _____ **Phone #:** _____

Billing Information

For patients under 18 or who have a legal guardian:

Guarantor: _____ **Address:** _____ **Phone #:** _____

Primary Ins: _____ **Address:** _____

Policy #: _____ **Group #:** _____

Policyholder: _____ **Relationship:** _____

DOB: _____ **SSN #:** _____

Secondary Ins: _____ **Address:** _____

Policy #: _____ **Group #:** _____

Policyholder: _____ **Relationship:** _____

DOB: _____ **SSN #:** _____

I understand that I will be responsible for any co-insurance, deductible, or spend-down not covered by my insurance. If any balance is not paid when due I understand that I will be responsible for the balance. I also understand that if the unpaid account is referred to an outside agency, I am responsible to pay all costs of collection including attorney fees. I hereby authorize the release of information to my insurance carrier or its intermediaries for all covered services rendered by North Atlanta Endocrinology and Diabetes, P.C.

Signature: _____ **Date:** _____