

AUGUSTA CARDIOLOGY CLINIC, P.C.

818 ST. SEBASTIAN WAY, SUITE 311
AUGUSTA, GEORGIA 30901

TELEPHONE (706) 724-3473
FAX (706) 722-7307

PATIENT REGISTRATION

PATIENT NAME: _____ S.S.#: _____
STREET ADDRESS: _____ DOB: _____
CITY/STATE: _____ ZIP: _____ SEX: M F
HOME PHONE: _____ MARITAL STATUS: S M W SEP D
EMERGENCY CONTACT: _____ TELEPHONE #: _____
RELATIONSHIP: _____
REFERRED BY: _____

PATIENT EMPLOYER INFORMATION

EMPLOYER'S NAME: _____ WORK #: _____
PATIENT'S OCCUPATION: _____

INSURED PERSON (IF NOT PATIENT)

NAME OF INSURED PERSON: _____ S.S.#: _____
EMPLOYER: _____ WORK #: _____
RELATIONSHIP: _____ DOB: _____

INSURANCE INFORMATION

PLEASE PROVIDE CARDS FOR VERIFICATION. THANK YOU!

**AUTHORIZATION TO RELEASE INFORMATION
AND ASSIGNMENT OF BENEFITS**

I AUTHORIZE THE RELEASE OF ANY MEDICAL INFORMATION NECESSARY TO PROCESS THIS CLAIM.
I PERMIT A COPY OF THIS AUTHORIZATION TO BE USED IN THE PLACE OF THE ORIGINAL.

SIGNATURE: _____ DATE: _____

I HEREBY AUTHORIZE **AUGUSTA CARDIOLOGY CLINIC** TO APPLY FOR BENEFITS ON MY BEHALF
FOR SERVICES PROVIDED. I REQUEST THAT PAYMENT FROM MY INSURANCE COMPANY BE MADE
DIRECTLY TO THIS PROVIDER.

I CERTIFY THAT THE INFORMATION I HAVE PROVIDED IS TRUE AND CORRECT. I UNDERSTAND
THAT I AM RESPONSIBLE FOR ANY BALANCE NOT COVERED BY MY INSURANCE COMPANY.

SIGNATURE: _____ DATE: _____