Athens Regional Physician Services-Hawthorne Medical Associates   Entered by________________

PATIENT INFORMATION FORM (Rev 4/2013)   Acct #: ________________________

Patient Name:			Social Security Number:	Sex: M F
MAILING Address:			Date of Birth:	Age:
City:	State:	Zip:	Marital Status: **S**ingle **M**arried **W**idowed **D**ivorced **Sep**arated	
Street Address, if different: City, State, Zip			RACE: (_) White (_) American Indian (_) Asia, India, Pakistan (_) Black/African American (_) More than one race (_) Decline to report (_) Other_____________	ETHNICITY: (_) Hispanic or Latino (_) NOT Hispanic or Latino -- LANGUAGE PREFERENCE: (_) English Specify if not English:
Home Phone:	Cell Phone:			
	E-Mail Address:			

Employer: Full Time Part Time			Retired? No Yes	Date of Retirement:
City:	State:	Zip:	In School? No Full Time Part Time	Name of School:
Work Phone:	Occupation:		Disabled? No Yes Reason:	

Spouse or Emergency Contact Name:			Relation to Patient: Spouse Son/Daughter Parent Friend Other __________		
Street Address:			Social Security #:	Date of Birth:	
City:	State:	Zip:	Home Phone:	Work Phone:	Cell Phone:

PRIMARY INSURANCE: (We will need to copy your insurance cards)

Insurance Company: ___________________________________ Type: PPO HMO POS

Name of Insured: ______________________________ DOB: _____________ SSN: __________________

Relation to Patient: Self Spouse Parent Other ___________________

Insured's Employer: ______________________________ Effective Date: ________________________

SECONDARY INSURANCE:

Insurance Company: ___________________________________ Type: PPO HMO POS

Name of Insured: ______________________________ DOB: _____________ SSN: __________________

Relation to Patient: Spouse Parent Other ___________________

Insured's Employer: Effective Date:

ASSIGNMENT OF BENEFITS:

Assignment of Benefits: I hereby assign all medical and/or surgical benefits to which I am entitled including major medical, Medicare, private insurance and any other plans to the office of Athens Regional Physician Services. This agreement will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original. I understand that I am financially responsible for all charges whether or not paid by said insurance. I authorize said assignee to release all information necessary to security the payment. If you choose not to sign you are still responsible for all charges.

Treatment Authorization: I authorized you to give me reasonable and proper medical care by today's standards.

Release of Information: I authorize release of my medical records to Athens Regional Physician Services, and from Athens Regional Physician Services to other healthcare providers, including human immunodeficiency virus, psychiatric, drug/alcohol abuse records, venereal disease and any other statutory protected diseases, as necessary for continued medical care, to obtain insurance reimbursement, or to comply with utilization review. I authorize this office to obtain previous medical records from other physicians and/or medical facilities including human immunodeficiency virus, psychiatric, drug/alcohol abuse records, venereal disease and any other statutory protected diseases. A faxed copy of this authorization can serve as an original.

Signature: ___________________________________ Date: ______________________________