

WELLSTAR SURGICAL ASSOCIATES OF MARIETTA, LLC
55 Whitcher St., Suite 130
Marietta, GA 30060

PLEASE PRINT & FILL IN COMPLETELY

Personal E-Mail Address _____		Cell phone # _____	
Name: _____		Sex: _____	Marital Status: _____
<small>(First)</small>	<small>(Middle)</small>	<small>(Last)</small>	<small>(F or M)</small> <small>M S W D</small>
Address: _____			
<small>(Street)</small>	<small>(City)</small>	<small>(State)</small>	<small>(Zip)</small>
Phone # (____) _____	Soc. Sec. #: _____	Birth date: _____	Age: _____
Referral: _____		List any drug allergies: _____	

Employer: _____	Employer Address: _____	Phone # (____) _____
If married, spouse name: _____	Birth date: _____	SS# _____
Parent or spouse employer: _____	Phone # (____) _____	
If you are a student, are you full time or part time? (Circle one)	Parent Name: _____	
Birth date of parent: _____	SS # of parent: _____	
Nearest relative (not living with you): _____		
Address: _____		

Primary Insurance: _____	Contract # _____	Group # _____
Address: _____		
Secondary Insurance: _____	Contract # _____	Group # _____
Address: _____		

I hereby authorize WELLSTAR SURGICAL ASSOCIATES OF MARIETTA, LLC to furnish to insurance carriers concerning my illness and treatment and I hereby assign all medical and/or surgical benefits to include major medical benefits to which I am entitled, including Medicare, private insurance and any other health plan to Wellstar Surgical Associates of Marietta, LLC rendered to myself or my dependents. I understand that I am responsible for any amount not covered by my insurance.

Signature: _____ Date: _____

I authorize any holder of medical or other information about me to release to the Social Security Administration and Health Care Financing Administration or its intermediaries or carrier any information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or to the party who accepts assignment. Regulations pertaining to Medicare assignment of benefits apply. I understand that I am responsible for any amount not covered by my insurance.

Signature: _____ Date: _____

Please indicate your preference below:

_____ Discuss my medical concerns only with me

_____ It is permissible to discuss my medical concerns with the following people should they contact my doctor.

1. _____ 2. _____

I understand that a written request by me will be required to alter the above, and I will note specifically with whom my doctor may discuss my case.

Patient/Guardian Signature

Date