Georgia Infectious Diseases, PC
5673 Peachtree Dunwoody Rd NE, Suite 600 · Atlanta, Georgia 30342
Phone: (404) 256-4111 · Fax: (404) 256-0040

PATIENT INFORMATION FORM

Full Name: ____ Date of Birth: ______________ Gender: F / M / T

Address: ____
Street Address *Apt/Unit #* *Zip Code*

Preferred Phone Number: ______________________ ☐ Cell ☐ Home OK to leave medical information on voice mail? ☐ Yes ☐ No

Secondary Phone Number: _____________________ ☐ Cell ☐ Home

Email Address: ____

Referring Physician: ____ Office Phone: _____________________________

Primary Care Physician: _______________________________________ Office Phone: _____________________________

Employer: ____ Employer Phone: ___________________________

Pharmacy: ____ Pharmacy Phone: ___________________________

Pharmacy Address: ____

Emergency Contact: ____ ________________ ____________________
Name *Relationship* *Phone Number*

Insurance Information

Type of Insurance: ☐ Commercial ☐ Medicare ☐ Medicaid ☐ Worker's Comp ☐ Self Pay

Primary Insurer: ____________________________________ Secondary Insurer: ________________________________

Does your insurer require a referral to be seen at a specialty practice? ☐ Yes ☐ No

PLEASE HAND YOUR INSURANCE CARD AND PHOTO ID CARD TO THE RECEPTIONIST.

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By signing below, I attest that the above information is correct to the best of my knowledge.

____ ____

Signature of Patient or Legal Surrogate **Date** **Time**

____ ____

Printed Name of Patient or Legal Surrogate **Relationship (If Legal Surrogate)**