GREATER ATLANTA ORAL FACIAL SURGERY

REGISTRATION FORM

(Please Print)

Today's date:	PCP:

PATIENT INFORMATION

Patient's Last name: First: Middle:	❑ Mr. ❑ Mrs.	❑ Miss ❑ Ms.	Marital status (circle one) Single / Mar / Div / Sep / Wid

Is this your legal name? ❑ Yes ❑ No	If not, what is your legal name?	(Former name):	Birth date: / /	Age:	Sex: ❑ M ❑ F

Street address:	Social Security no.:	Home phone no.: ( )

City:	State:	Zip Code:	Email:

Occupation:	Employer:	Employer phone no.: ( )

Referred by: ❑ Dr. _____ ❑ Insurance Plan ❑ Hospital

❑ Family ❑ Friend ❑ Close to home/work ❑ Internet ❑ Other

INSURANCE INFORMATION

(Please give your insurance card to the receptionist.)

Person responsible for bill:	Birth date: / /	Address (if different):	Home phone no.: ( )

Occupation:	Employer:	Employer address:	Employer phone no.: ( )

Is this patient covered by insurance? ❑ Yes ❑ No

Please indicate Dental insurance

Subscriber's name:	Subscriber's S.S. no.:	Birth date: / /	Group no.:	Policy no.:

Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other

Name of Medical insurance:

Subscriber's name:	Subscriber's S.S. no.:	Birth date: / /	Group no.:	Policy no.:

Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address):	Relationship to patient:	Home phone no.: ( )	Work phone no.: ( )

PATIENT AUTHORIZATION

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance or deductible. I also authorize Greater Atlanta Oral Facial Surgery or insurance company to release any information required to process my claims. I authorize Dr. Abtin Shahriari and/or staff to perform an oral maxillofacial exam and take any x-rays required for this exam. I acknowledge that a copy of the Notice of Privacy Practices has been made available to me and all questions have been answered regarding this notice.

_____ _____

Patient/Guardian signature *Date*