[illegible] 2003 19:21 7709848825 ALPHA PAGE 01

## PATIENT REGISTRATION

[illegible] HEAR ABOUT OUR OFFICE?:

| LAST NAME, FIRST, MIDDLE | DATE OF BIRTH | AGE | BIRTH PLACE | SOC. SEC. NO. |
|---|---|---|---|---|
| [illegible] CRISTIANO FURTADO | 05/03/7[illegible] | 26 | | [illegible]22864429 |

| STREET ADDRESS | APT. NO | HOME PHONE | WORK PHONE |
|---|---|---|---|
| [illegible] POWERS FERRY RD | I | (6) 887-4779 | (6[illegible]) 887-4779 |

| CITY | COUNTY | STATE | ZIP | SEX | MARITAL STATUS |
|---|---|---|---|---|---|
| [illegible]ETTA | COBB | GA | 30067 | ☒ M ☐ F | ☐ S ☐ M ☐ W ☐ D |

[illegible] PATIENT (LAST NAME, FIRST, MIDDLE) — PHONE

IN THE EVENT OF AN EMERGENCY NOTIFY — RELATIONSHIP — PHONE

STREET ADDRESS — APT. NO — CITY — STATE — ZIP

New Hire

[illegible] EMPLOYER — CITY — STATE — TEL. NO.

SPOUSE'S OR PARENT EMPLOYER — CITY — STATE — TEL. NO.

[illegible] EXPECTED AT TIME OF VISIT - I PLAN TO PAY BY:

CASH — CHECK — CREDIT CARD

MEDICARE NUMBER

INSURANCE COMPANY — NAME OF INSURED

36 to 40 hours wkly

GROUP NO — CERTIFICATE NO.

SUPPLEMENTAL INS. COMPANY — PHONE NO. — NAME OF INSURED

GROUP NO — CERTIFICATE NO.

$10.00

### PAYMENT POLICY AND INFORMATION RELEASE

I authorize the release of any medical information necessary to process insurance claims. I authorize payment of medical benefits to Dr. Daniel E. McBrayer if assignment is taken in service.

SIGNATURE ________ DATE ________

I understand that any balance remaining on my account after 60 days may be turned over for collection and will incur finance charges of 1.5% per month. **I UNDERSTAND THAT I AM RESPONSIBLE FOR ANY CHARGE FOR THE PATIENT LISTED ABOVE REGARDLESS OF INSURANCE. ADMIN COST FOR MEDICAL RECORDS FEE $25.00.**

SIGNATURE ________ DATE ________

Even though an insurance claim may be filed, you will receive a statement each month if your account has a balance due. This office cannot accept responsibility for collecting your insurance claim.

**THIS ENTIRE FORM MUST BE COMPLETED**