

MARTHA B. BOONE, M.D., LLC
960 Johnson Ferry Rd., Suite 245
Atlanta, Georgia 30342

Patient Registration Form

Patient Information

Name _____
Last First Middle

Address _____

City _____ State _____ Zip _____

Date of Birth _____ Age _____ SS# _____

Home Phone _____ Cell _____

Marital Status (circle) Single Married Widowed Divorced

Email Address _____

Occupation _____

Employed By _____

Work Phone _____ Ext _____

Are You Retired? _____ Date ____/____/____ Age _____

Spouse/Guardian Information

Spouse/Guardian Name _____

SS# _____ DOB _____ Phone _____

Physician Information

Referring MD _____

Phone _____ Fax _____

Primary Care MD _____

Phone _____ Fax _____

Gynecologist _____

Phone _____ Fax _____

Emergency Contact Information

Emergency Contact _____

Relation _____ Phone _____

Insurance Information

Primary Insurance _____

Address _____

City _____ State _____ Zip _____

Policy # _____ Group # _____

Policy Holder's Name _____

DOB _____ Effective Date _____ SS# _____

Secondary Insurance _____

Address _____

City _____ State _____ Zip _____

Policy # _____ Group # _____

Policy Holder's Name _____

DOB _____ Effective Date _____ SS# _____

Pharmacy Information

Pharmacy Name _____ Phone _____

Pharmacy Name _____ Phone _____

Treatment Approval / Insurance Authorization

Payment for office services is due on the day of the visit. Payment may be made by check, charge or cash. All Insurance and financial arrangements should be made with our business office prior to medical care. I hereby authorize Martha B. Boone, M.D. to treat me and to furnish information concerning my illness or treatment to an insurance carrier, should it be necessary to process a claim I understand that I am responsible for payment regardless of insurance coverage. I recognize that the medical insurance I possess may not completely cover the fee(s) for professional services rendered to me. I authorize payment of medical benefits directly to Martha B. Boone, M.D. I hereby state all information provided is true and complete to the best of my knowledge

I acknowledge and understand the payment policy stated above.

Signature

Date