PATIENT INFORMATION

For the Facility checked below:

☐ HyperbaRXs at Kennestone *(d.b.a. Cobb Hyperbaric Medicine)*
☐ HyperbaRXs at Lithonia *(d.b.a. DeKalb Hyperbaric Medicine & Wound Care Center)*
☐ HyperbaRXs at Northside Forsyth *(d.b.a. North Georgia Center for Hyperbaric Medicine & Wound Care)*
☐ HyperbaRXs at Saint Joseph's *(d.b.a. Hyperbaric Medicine of North Atlanta)*

Name: ____ Soc. Sec. #: __________-_____-__________

D.O.B.: _________________________ Age: __________

Marital Status: Single Married Divorced Widowed

Home Telephone: ________-________-________________

Address: ____
____

Secondary Telephone: ________-________-________________

Cellular Telephone: ________-________-________________

E-mail Address: ____

E-mail: __________________________________

Employer Name: ____

Employer Telephone: ________-________-________________

Employer Address: ____
____

Primary Physician: ____ Referring Physician: ___________________________________

Primary Insurance: ____ Secondary Insurance: ___________________________________

Case Mgr. Telephone: ________-________-_____________________ Guarantor: ___________________________________

Emergency Contact: ____ Contact's Relationship: ___________________________________

Contact's Telephone: ________-________-_____________________

I authorize consultative services and related treatment by **HYPERBARIC PHYSICIANS OF GEORGIA**, this **FACILITY**, and its agents along with the releases of any necessary medical information needed in my care, or in the processing of medical claims to **HYPERBARIC PHYSICIANS OF GEORGIA**, this **FACILITY**, and its agents. I also request the payment of medical benefits for the care and services provided to **HYPERBARIC PHYSICIANS OF GEORGIA**, this **FACILITY**, and its agents.

I understand and agree to be responsible for the balance on my account for any professional/technical services rendered by **HYPERBARIC PHYSICIANS OF GEORGIA**, this **FACILITY**, and its agents. I certify that the information provided is true and correct to the best of my knowledge. I will notify **HYPERBARIC PHYSICIANS OF GEORGIA** and this **FACILITY** of any changes in the above information immediately.

____ (Signature of Patient) ______________________ (Date)

____ (Witness)