HYPERBARXS O2

Your Partner In Healing

HYPERBARIC PHYSICIANS OF GEORGIA

☐ **HyperbaRXs at Kennestone**
61 Whitcher Street,
Suite 2150, Marietta, GA 30060
(Phone) 770-422-4268

☐ **HyperbaRXs at Northside Forsyth**
1505 Northside Boulevard, Suite 1300,
Cumming, GA 30041
(Phone) 770-771-6400

☐ **HyperbaRXs at Saint Joseph's**
5665 Peachtree Dunwoody Road,
Suite G9, Atlanta, GA 30342
(Phone) 678-229-2800

PATIENT INFORMATION SHEET

Please Print

PATIENT

Patient Name: _____ **Social Security#:** _____

Date of Birth: _____ **Age** _____ ☐ **Single** ☐ **Married** ☐ **Divorced** ☐ **Widowed**

Address: _____ **City:** _____ **State:**____ **Zip:** _____

Phone#: _____ **Cell Phone#:** _____

Email: _____

Patient's Employer: _____ **Employer Phone#:** _____

Emergency Contact: _____ **Phone#:** _____ **Relation:** _____

PHYSICIANS

Primary Physician: _____ **Phone#:** _____

Referring Physician: _____ **Phone#:** _____
☐ **Check if same as above**

INSURANCE

Primary Insurance: _____ **Secondary Insurance:** _____

ID #: _____ **Group #:** _____ **ID #:** _____ **Group #:** _____

Worksman's Compensation Case Manager: _____ **Phone#:** _____

Name of Responsible Party: _____ **Relation:** _____
(If Not Patient, Print Name of Guarantor)

I do hereby assign all medical and/or surgical benefits to which I am entitled, including all government and private insurance plans, to this office. This assignment will remain in effect until revoked by me in writing. I understand I am responsible for all charges not paid by my insurance. I authorize this office to secure payment.

I authorize consultative services and related treatment by HYPERBARIC PHYSICIANS OF GEORGIA, this FACILITY, and its agents along with the release 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 assign the payment of medical benefits for the care and services provided to 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/ Parent/ Guardian or Authorized Representative *Date*
(Guardian or Authorized Representative must attach documentation of such status.)

_____ _____
Printed name of Authorized Representative *Relationship / Capacity to patient*

_____
Address and telephone number of authorized representative