



Your Partner In Healing PATIENT INFORMATION SHEET

Please Print



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

Patient Name: _____ Social Security#: _____

Date of Birth: _____ Age _____ Single Married Divorced Widowed

Race _____ Male Female

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 #: _____

Workman'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
(Guardian or authorized representative must attach documentation of such status.)

Date

Printed Name of Authorized Representative

Relationship / Capacity to Patient

Address and Telephone Number of Authorized Representative