ATLANTA CENTER FOR MEDICINE
PATIENT REGISTRATION FORM

FROM THE LIST BELOW, PLACE AN "X" IN THE SPACE TO THE LEFT OF THE DOCTOR YOUR APPOINTMENT IS WITH:

____Steven J. Anander, M.D. **____Ellen M. Ferguson, D.O.** **____D. Timothy Daugherty, M.D.**
____Thomas J. Mizell, M.D. **____Larry G. Ray, M.D.** **____Jitendra P. Singh, M.D.**

IN THE SECTION BELOW, PLEASE PROVIDE US WITH INFORMATION ABOUT YOURSELF:

SEX: ☐Male ☐ Female YOUR TITLE: ☐ Mr. ☐ Mrs. ☐ Ms. ☐ Dr. Other _____

Name (Last, First, MI)_____Nick Name:_____

Physical Address (No PO Box)_____ Apt #_____

City:_____ State_____ Zip_____

Mailing Address if different than above (PO Box allowed)_____

☐Home Phone _____ ☐Cell Phone_____ ☐Work Phone_____Ext_____

(Place a check mark next to the preferred number above where may we leave messages regarding Appointment Reminders, Normal Blood Tests, Normal Diagnostic Results and Medication Info.) May we text reminders to your cell? ☐Yes ☐No

Date of Birth_____ Marital Status _____ Social Security # _____

Patient's Employer Name & Address _____

Emergency Contact _____ Phone _____ Relationship _____

Who referred you? _____Are they: ☐Family/Friend ☐Insurance Co ☐Internet Search ☐Doctor ☐Other

Primary Insurance Carrier _____
(We do not file insurance for Motor Vehicle Accidents. You must self-pay and file for reimbursement with your auto insurance)

ID#_____ Group #_____ Group/Plan Name _____

Insured Name_____ Their Birth Date_____ Relationship_____

Email address _____ I would like access to patient portal ☐Yes ☐No

RACE (Please circle): Asian; African-American; Hispanic; White; Refuse to report; Other(specify): _____

ETHNICITY (Please circle): Hispanic/Latino; Not Hispanic/Latino; Refuse to report LANGUAGE:_____

Pharmacy Name _____ Pharmacy Phone _____

Pharmacy Address _____

***By signing this consent form you are agreeing that Atlanta Center for Medicine can request and use your prescription medication history from other healthcare providers and/or third party pharmacy benefit payers (for treatment purposes only.)*

The above information is true to the best of my knowledge. I authorize Atlanta Center for Medicine (ACM) or insurance company to release any information required to process my claims. I authorize my insurance benefits to be paid directly to ACM. I understand that I am financially responsible for any balance. I understand that payment is due at the time of service, and that ACM reserves the right to dismiss patients that fail to keep their accounts current after reasonable attempts to collect payment have been made. I further agree to pay all reasonable costs and late fees if my account is turned over to collections.

Patient (or Guardian) Signature _____ Date_____

Responsible Party _____ Relationship to Patient _____