THE HOPE CENTER OF GEORGIA

PATIENT INTAKE FORM

Patient Information

Name:_____ Soc. Sec._____
Last Name First Name Middle Initial

Address_____

City_____ State_____ Zip_____

Sex ☐M ☐ F Age_____ Birth date ____/_____/_____ ☐ Single ☐ Partnered ☐ Widowed ☐Separated ☐ Divorced

Patient Employed By_____ Occupation_____

Home Phone_____ Mobile phone_____ Work Phone_____

How do you prefer to be contacted? ☐ mobile ☐ home phone ☐ email_____

May we leave a message on your ☐ mobile ☐ home phone? ☐ yes ☐ no

In case of emergency, we should contact:_____

Relationship:_____ Phone:_____

Primary Insurance

Person Responsible for Payment:_____
Last Name First Name Middle Initial

Relationship to patient_____ Birth date_____ Soc Sec #_____

Address_____ Phone_____
If different from patient

City_____ State_____ Zip_____

Person Responsible Employed by: _____ Occupation:_____

Business Address_____ Bus. Phone_____

Insurance Company_____ Ins. ID#_____

Group #_____

Assignment and Release

I, the undersigned, certify that I or my dependent have insurance coverage with_____
Name of Insurance Company

And assign directly to my provider all insurance benefits otherwise payable to me for services rendered. I understand that **I am ultimately responsible for all charges** accumulated. I hereby authorize the doctor to release all information necessary to secure the payment of benefits, and authorize the use of this signature on all insurance submissions.

_____ _____ _____
Responsible Party Signature Relationship Date

I give permission for treatment of myself/my dependent to my assigned provider.

Responsible Party Signature	Relationship	Date