**Athens Area Internal Medicine**

**(Circle one)** **Dr. Johnson** **Dr. Morel** **Dr. Herrin**

Patient Name _____

Address _____

City _____ State _____ Zip _____

Home Phone _____ Cell Phone_____ Email _____

Date of Birth _____ SSN# _____ [ ]Male [ ]Female

Employer_____

[ ] Asian [ ] Black [ ] Hispanic [ ] White [ ] Other [ ] Divorced [ ] Married [ ] Single [ ] Widow

Preferred Drug Store_____ Phone #_____

**Request for Alternative Communications**

Messages may be left for me by the following alternative mean:

Voice Mail [ ] Yes [ ]No Text [ ] Yes [ ] No

**My messages and/or health information may be given to the following representatives:**

| Name | Relationship |
|---|---|
| _____ | _____ |
| _____ | _____ |

**Emergency Contact**: List Persons that we can contact in case of an emergency.

| Name | Phone | Relationship | Release Information |
|---|---|---|---|
| _____ | _____ | _____ | Y/N |
| _____ | _____ | _____ | Y/N |

Primary Insurance Company: _____ Secondary Insurance: _____

**Assignment of Benefits:** I hereby assign all medical and/or surgical benefits to which I am entitled including major medical, Medicare, private insurance, and any other plans to Athens Area Internal Medicine. This agreement will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. **I understand that I am financially responsible for all charges whether or not paid by said insurance.** I hereby authorize said assignee to release all information necessary to secure the payment. If I choose not to sign, I will still be responsible for all charges.

Signed_____ Date_____