Northcrest Family Medicine
7768 Cumming Highway, Suite 300,
Canton GA 30115
PHONE 770-720-2113, FAX 770-704-7365

Patient Name:	
Mailing Address:	

Best Contact Phone:	**Secondary Phone:**	**Work Phone:**

Date of Birth:	**Marital Status:**
Social Security Number:	**Email Address:**
Employer Name:	**Address:**
Emergency Contact Name:	**Phone Number:**
Relationship:	
Responsible Party:	
Responsible Party Address:	
Primary Insurance:	**Phone Number:**
Subscriber Name:	**Date Of Birth:**
Subscriber ID:	**Group Number:**
Subscriber Name:	**Date Of Birth:**
Subscriber ID:	**Group Number:**

Secondary Insurance:	**Phone Number:**
Subscriber Name:	**Date Of Birth:**
Subscriber ID:	**Group Number:**
Subscriber Name:	**Date Of Birth:**
Subscriber ID:	**Group Number:**

Do you have a *LIVING WILL* or *ADVANCE DIRECTIVE*?	***YES or NO***

Pharmacy Name:	**Pharmacy Number:**

I hereby authorize you to release any information, including the diagnosis and record of any treatment or examination rendered to me or my child during the period of such care to third party payers and/or other health practitioners. I authorize and request my insurance company to pay benefits otherwise payable to me directly to Northcrest Family Medicine. I understand that my insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on behalf of myself or my dependent.

_____ _____

Patient's Signature (Parent's signature if patient is under 18) Date