



Atlanta Hyperbaric & Wound Care Clinic, L.L.C.
Glenn L. Goodhart, M.D., J.D.
(404) 501-7316 or (404) 501-7312

Welcome to Our Office

Today's Date _____

Patient's Name _____ **Birth Date** ____ / ____ / ____ **SS#** _____

Street Address _____ **City** _____ **State/Zip** _____

Home Phone# _____ **Business/Cell Phone#** _____

Employer Name _____ **Address** _____

Employment Status ___ **Full-time** ___ **Part-time** ___ **Unemployed** ___ **Retired**

Marital Status ___ **Single** ___ **Married** ___ **Widowed** ___ **Divorced** ___ **Separated** ___ **Sex** ___ **M** ___ **F**

Emergency Contact _____ **Relationship to Patient** _____

Address _____ **Daytime Phone#** _____

Responsible Party

Person Responsible For Payment:

Same As Above _____

Name _____ **Responsible Party SS#** _____

Address _____ **Phone#** _____

Relationship to Patient _____

INSURANCE CARRIER

Primary Insurance _____ **Policy#** _____ **Group#** _____

Policy Holder's Name _____ **SS#** _____ **Relationship** _____

Secondary Insurance _____ **Policy#** _____ **Group#** _____

Policy Holder's Name _____ **SS#** _____ **Relationship** _____

Referring Physician _____ **Phone #** _____

*All professional services rendered are charged to the patient. Necessary forms will be completed to help expedite insurance carrier payments. However, the patient is responsible for all fees, regardless of insurance coverage. It is also customary to pay for services when rendered unless other arrangements have been made in advance with our office.

I authorize any holder of medical or other information about me to release to the Social Security Administration and Health Care Financing Administration or its intermediaries or carriers any information needed for this or a related Medicare claim/other Insurance Company claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or to the party who accepts assignment. I understand it is mandatory to notify the health care provider of any other party who may be responsible for paying for my treatment. I also authorize that payment be made directly to the provider.

Patient/Guardian Signature_____ **Date**_____