MATTHEWS W. GWYNN, M.D.
KEITH A. SANDERS, M.D.
LISA H. JOHNSTON, M.D.
JAMES M. KIELY, M.D., PH. D.
BRANDY HUGHES, F.N.P.-C

Welcome to our office .

Date: _____

ATLANTA NEUROLOGY, P.C.

Account #: _____

PATIENT INFORMATION

Title
Name First M.I. Last

Address City State Zip

Home Phone ( ) Cell or Alternate # ( ) S.S. #

Birthdate Age Sex: (Circle) M F Marital Status ☐ M ☐ S ☐ D ☐ W

Race: ☐ White ☐ African American ☐ Asian
☐ American Indian or Alaskan Indian
☐ Native Hawaiian / Other Pacific Islander
☐ Other Race_____ ☐ Unknown

Ethnicity: ☐ Decline ☐ Hispanic or Latino
☐ Not Hispanic or Latino

Preferred Method of Contact: ☐ Home ☐ Cell ☐ Work
☐ Email _____

Spouse's Name **Spouse DOB:** Work Phone ( )

Patient's Employer Work Phone ( )

Address City State Zip

Local Relative or Friend Phone ( )

Pharmacy Name: Phone ( )

INSURANCE INFORMATION

Primary Insurance Company Phone ( )

Insured's Name I.D. # Group #

Secondary Insurance Company Phone ( )

Insured's Name I.D. # Group #

PRIMARY CARE DOCTOR:

IS POLICYHOLDER OTHER THAN SELF? IF SO PLEASE COMPLETE BELOW:

☐ Primary Insurance ☐ Secondary Insurance

Policyholders
Name First M.I. Last Relationship: (Circle One)
Spouse, Parent, Other

SS#: DOB: Employer:

Home Phone ( ) Work Phone ( )

I authorize payment of health insurance benefits directly to Atlanta Neurology for services rendered, and I authorize the use of this signature for all insurance claims. Regulation pertaining to medical assignment of benefits apply. I authorize the release of any medical information necessary to secure payment of benefits. I further authorize the release of medical information to other physicians and hospitals involved in my treatment. I permit a copy of this authorization to be used in place of the original.

I agree that I am responsible for understanding my health insurance policy and its requirements for coverage, and for complying with any regulations my insurance may have regarding referrals and pre-authorizations. Co-pays, deductible and/or co-insurance payments are due at the time services are provided. I agree to make immediate payment in full of any amount exceeding what my insurance company pays, except where exempt by contractual agreement. I further agree to pay all reasonable costs of collection and attorney's fees, if any.

Signature _____ Date _____