❖ Advent Health Group, P.C. ❖

REFERRED BY					
PATIENT NAME First Middle Last					PLEASE CHECK THE NUMBER AT WHICH WE MAY LEAVE A DETAILED MESSAGE.
SEX • Male • Female	DATE OF BIRTH	AGE	MARITAL STATUS • M • S • W • D	SOCIAL SECURITY NUMBER	HOME PHONE NO. ☏ ( ) •
ADDRESS Street City State Zip					DRIVER'S LICENSE St. #
ARE YOU • Employed • Full-Time Student • Part-Time Student			OCCUPATION OR, IF STUDENT, GRADE		WORK OR SCHOOL PHONE NO. ☏ ( ) •
EMPLOYER OR SCHOOL NAME AND ADDRESS					CELL PHONE NO. ☏ ( ) •
E-MAIL ADDRESS					PHARMACY PHONE NO. ☏ ( )

All contact information given above authorizes AHG to use that information for contact and informational purposes.

EMERGENCY CONTACT NAME	RELATIONSHIP TO PATIENT	PHONE NO. ( )
FAMILY DOCTOR		PHONE NO. ( )

PRIMARY INSURANCE

If no insurance please check •

INSURANCE COMPANY			INSURED (If other than patient please complete)		
INSURANCE COMPANY NAME OR MEDICARE INFORMATION			POLICY IN NAME OF (Insured)		HOME PHONE NO.
POLICY /ID NUMBER/MEMBER ID NUMBER	GROUP NUMBER		INSURED'S ADDRESS Street		
INSURANCE COMPANY ADDRESS Street			City State Zip		
City	State	Zip	PATIENT'S RELATIONSHIP TO INSURED	DATE OF BIRTH	SEX • M • F
INSURANCE COMPANY PHONE NUMBERS Verifying: ( )	Claim: ( )		EMPLOYER'S NAME &PHONE NUMBER		SOC. SEC. NO. OF INSURED

SECONDARY INSURANCE (IF APPLICABLE)

INSURANCE COMPANY			INSURED (If other than patient please complete)		
INSURANCE COMPANY NAME OR MEDICARE INFORMATION			POLICY IN NAME OF (Insured)		HOME PHONE NO.
POLICY /ID NUMBER/MEMBER ID NUMBER	GROUP NUMBER		INSURED'S ADDRESS Street		
INSURANCE COMPANY ADDRESS Street			City State Zip		
City	State	Zip	PATIENT'S RELATIONSHIP TO INSURED	DATE OF BIRTH	SEX • M • F
INSURANCE COMPANY PHONE NUMBERS Verifying: ( )	Claim: ( )		EMPLOYER'S NAME &PHONE NUMBER		SOC. SEC. NO. OF INSURED

If patient is under 18 years of age, please complete the following:

ACCOMPANYING ADULT'S NAME	RELATIONSHIP TO PATIENT	SIGNATURE

INSURANCE AUTHORIZATON AND ASSIGNMENT

I authorize AHG. to release medical information that may be necessary to request claim reimbursement from my insurance company to whom claims have been submitted.

I certify that the information I have reported regarding my insurance coverage is correct. I also assign the claim payment to be made payable to AHG directly and I understand that any overpayment will be refunded to me from the doctor's office.

I understand that I will be responsible for any unpaid balance. I further understand that, if I have insurance with which AHG. participates, I will be responsible for any unpaid balance remaining after 45 days.

I understand that if any unpaid balance necessitates legal action (attorney/court fees/collection agency fees) to collect this balance, I will be responsible for all attorney, court costs and collection agency fees.

Signature____ **Date** ________________

(Insured or authorized person)12/16/08 Z:RegistrationFroms-Both