



Patient Registration Form

I. Personal Information

Patient Name: _____
(First Name) (Middle) (Last)

Street Address: _____
(Mailing Address)

(City) (State) (Zip)

1. Home Phone: _____ 2. Work Phone: _____

3. Mobile Phone: _____ E-mail: _____

Please circle (1, 2 or 3 for the best number our office can reach you): 1 2 3

Would you like to have internet access to our office YES _____ NO _____
(If yes, please make sure your e-mail is on this form i.e., make appts, view labs, communicate with your provider on our secure patient portal)

Date of Birth: _____ SS# _____ - _____ - _____
(To bill insurance)

Marital Status: _____

II. Insurance Information

Primary Insurance: _____ Phone #: _____

Address: _____
(Billing Address) (City) (ST) (Zip)

Subscriber Name: _____

Subscriber ID: _____ Group #: _____

III. Employer Information

Employer Name: _____ Phone#: _____

Address: _____
(Mailing Address) (City) (ST) (Zip)

IV. Emergency & Pharmacy Contact Information

Emergency Contact Name: _____

Phone#: _____

Pharmacy Name: _____

Phone#: _____

V. Internal Medicine Associates Policy

Please note that Internal Medicine Associates requires payment at time of service for the total amount not covered by insurance. Our office will be happy to file your charges for services rendered to your insurance company. If you are a participating member of a managed care plan, we will expect you to pay your co-payment and/or any other fees that are non-covered at the time of your visit. If your insurance is one that we do not participate with or you are a self-pay patient, you will be asked to pay in full for your visit upon check out.

We participate on many plans and it is difficult to always be 100% accurate with the changes that insurance companies make in regard to laboratory work, referral requirements, pre-certifications, etc. We attempt to keep our office staff fully educated to most recent changes and updates. We feel strongly that it is also the patient's responsibility to be aware of how their insurance plans works and your benefit package. Any patient who is seen and fails to notify our office of any changes in their insurance that in turn deems your services as non-covered will be billed directly for these charges.

You will be required to sign a patient information sheet on every visit to verify your information is correct and current.

By signing this form, I give Internal Medicine Associates of Johns Creek, Inc. and its providers to treat the patient listed above. In addition, I give authorization to file my insurance claim and assign benefits to Internal Medicine Associates of Johns Creek, Inc. By signing this, I also agree to the above information and conditions.

Thank you for choosing Internal Medicine Associates. We appreciate your business and will do everything we can to provide you with the highest level of medical care you deserve.

(Signature of Patient or Guardian)_____
(Date of Signature)_____
(Print Name)**Internal Medicine Associates of Johns Creek**

Dr. Samantha B. Benson MD, Dr. Erica L. Peters MD

Karon P. Dunn FNP-C, Julie T. Michelitch FNP-C

Michelle Hall FNP-C

3340 Paddocks Parkway

Suwanee, GA 30024

Office 678-474-9633

Fax 678-474-9752

www.imajohnscreek.com