PEACH TREE MEDICAL CENTER

Please Print 2015

Patient Demographics

Legal First Name	Legal Last Name	Suffix	Preferred First Name	
Permanent Address	City	State	Zip	
Home Phone#	Cell Phone #	Social Security#	Gender	Race
Birth Date	Language	Marital Status	Today's Date	

Have you been treated by any other health care facility before?
If so where?

Emergency Contact Information

Contact Name		Contact Phone #	
Contact Address	City	State	Zip
Relationship to Contact			
Alt. Contact Name		Contact Phone#	Relationship

Patient Employment Information

Employment Status		Employer	
Address	City	State	Zip
Occupation	Employment Contact	Phone #	Fax #

Responsible Party Information

Responsible Party's Legal Name		DOB	Social Security #
Responsible Party Address	City	State	Zip

Medical Insurance Information (Please Present Insurance Card With This Form)

Policy Holder's Legal Name		DOB	Social Security #
Name of Insurance Company		Policy #	
Address of Ins. Company	City	Sate	Zip

Do you have a Living Will or Advance Directives in place? Circle Yes or No
Do you give us authorization to treat you at this facility? Circle Yes or No **Please sign** _____