NORTH GEORGIA
Allergy Asthma
& Immunology LLC

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Patient Registration

PATIENT MRN#: _____ Referring Physician: _____
DATE: _____ Address: _____
_____
_____

PATIENT INFORMATION
Last Name: _____ First Name: _____ Middle Name: _____
SSN: _____ Birth Date: _____ Sex: _____
Billing Address: _____ County: _____
_____ State: _____ Zip: _____
Home Phone: _____ Work Phone: _____ Cell Phone: _____
Marital Status: _____ Student Status: ❒ Yes ❒ No ❒ Veteran ❒ Smoker
Email: _____ Language: _____
Ins. Company: _____ Medicare #: _____ Medicaid #: _____
Primary Care Dr.: _____
Address: _____ Phone: _____
_____ State: _____ Zip: _____
Employer (if patient is a minor, this does not apply)
Phone: _____ Occupation: _____
HAS ANY MEMBER OF YOUR FAMILY BEEN TREATED BY OUR PHYSICIAN(S) BEFORE? ❒ Yes ❒ No
IF THE ANSWER IS YES, PLEASE GIVE THE PATIENT'S NAME: _____

RESPONSIBLE PARTY INFORMATION
IF THE PATIENT IS A MINOR, the parent the child lives with is the responsible party:
Responsible Party: _____ SSN: _____ DOB: _____
Address: _____ Phone: _____
_____ State: _____ Zip: _____
Employer: _____ Emp. Phone: _____
Occupation: _____ Ins. Company: _____

SPOUSE INFORMATION OR OTHER PARENT
Name: _____ Occupation: _____
Employer: _____ Phone: _____

INSURED INFORMATION
Patient's Relationship to Insured (Spouse, Child, Dependent, Other): _____
If 'Other', please specify: _____
Name of Insured: _____ SSN: _____ DOB: _____
Address: _____ Phone: _____
_____ State: _____ Zip: _____