OCONEE
Physician Practices

Patient Information							
Last Name						Social Sec #	
First Name						Birth Date	
Middle Name						Sex (M or F)	
Street Address						Race	
Suite / Apt #						Primary Language	
City		State		Zip		Marital Status	
Mailing Address						Legal Guardian	
City		State		Zip		Legal Guardian's Primary Phone	
Home Phone		Work Phone				Cell Phone	
Email Address							

Guarantor Information (Person Responsible For Bill)							
Last Name						Social Sec #	
First Name						Birth Date	
Middle Name						Sex (Male or Fem)	
Street Address						Relationship	
City		State		Zip		Home Phone:	
Mailing Address						Work Phone:	
City		State		Zip		Cell Phone:	

Employment Information			
Patient's Employer		Employer Phone	
Spouse's Employer			

Emergency Contact Information					
Name		Relationship		Phone	

Physician Information			
Name of Family Physician		City/State	
Name of Referring Physician		City/State	

Insurance Information For Patient– Provide complete and provide copy of insurance card(s)		
Primary Insurance Company:	Name of Insured:	Relationship to Insured:
	Birthday of Insured:	Their Social Security #:
Secondary Insurance Company:	Name of Insured:	Relationship to Insured:
	Birthday of Insured:	Their Social Security #:
Additional Insurance Company:	Name of Insured:	Relationship to Insured:
	Birthday of Insured:	Their Social Security #:

Assignment of Benefits: I hereby authorize payment of medical benefits directly to Oconee Physician Practices for their services and to release any information acquired in the course of my examination or treatment for insurance purposes. I understand that records may be transmitted electronically or by mail as required.

Signature Of Patient Or Guardian >> _____ **Date:** _____