

PEACHTREE NEUROSURGERY, P.C.

Max Steuer, M.D.
 Christopher Tomaras, M.D.
 Tom Morrison, III, M.D.

Date: _____

Account: _____

REFERRING DOCTOR:			PRIMARY CARE DOCTOR:		
Patient Name	First	M.I.	Last	Social Security#:	
Address		City		State	Zip
Home Phone())		Cell or Alter. #())		E-Mail Address:	
Birthdate	Age	Sex: (circle) M F	Marital Status	Active Duty Military	Y N
Patient's Employer			Work Phone())		
Address		City		State	Zip
Spouse's Name		Spouse DOB:		Work Phone())	
Emer. Contact		Relationship:		Phone())	
<i>Is this injury related to a Motor Vehicle Accident?</i>			<i>If "yes," are you the policyholder?</i>		

Primary Insurance Company		HMO POS PPO	Phone())
Address		City	State Zip
Insured's Name		ID#	Group#
Secondary Insurance Company		Phone())	
Address		City	State Zip
Insured's Name		ID#	Group#

IS POLICYHOLDER OTHER THAN PATIENT? IF SO, PLEASE COMPLETE BELOW.

Policyholder's Name	First	M.I.	Last
S.S.#	DOB:		Relationship: Spouse Parent Other
Home Phone())		Work #())	
Employer		Holder of Primary or Secondary Policy?	

I authorize any holder of medical or other information about me to release to my insurance company or to the Social Security Administration and Health Care Financing Administration or its intermediaries or carrier any information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or to the party who accepts assignment. Regulations pertaining to medical assignments of benefits apply. I hereby authorize my primary care provider, referring physician, and/or other medical facilities to release any information and records requested by Peachtree Neurosurgery, P.C. deemed necessary for my treatment.

Patient Signature _____

Date _____