INTEGRITY
HEALTH & WELLNESS

: 912-490-4325 : 912-490-2873 | 808 Beacon Street
: www.integrityhealthga.com | Waycross, GA 31501

PATIENT INFORMATION

Patient Name: _____ **Date of Birth:** _____ **Age:** _____

SSN: _____ **Gender:** M/F **Marital Status:** Single/ Married/ Widowed/ Divorced

Race: _____ **Ethnicity:** _____

Mailing Address: _____
City: _____ **State:** _____ **Zip:** _____

Home Phone: _____ **Work Phone:** _____

Cell Phone: _____ **Employer:** _____

Employer Phone #: _____ **Email Address:** _____

May we leave information on your voicemail? Yes or No

Emergency Contact

Name: _____ **Phone:** _____

Relationship to Patient: _____

Parent or Guardian Responsible for Bill

Name: _____ **Date of Birth:** _____ **Age:** _____

Home Phone: _____ **Work Phone:** _____

Cell Phone: _____ **Relationship to Patient:** _____

Mailing Address: _____

City: _____ **State:** _____ **Zip:** _____

Alan Morton, MD
Internal Medicine
Board Certified

Alison Alderin
MSN, FNP-C

Rosalyn A. Thomas
APRN, MSN, FNP-C, DNP

Primary Insurance Information

Name of Insurance Co: _____

Address of Insurance Co: _____

Policy #: _____ **Group#:** _____

Insured Relationship to Patient: _____

Secondary Insurance Information

Name of Insurance Co: _____

Address of Insurance Co: _____

Policy #: _____ **Group #:** _____

Insured Relationships to Patient: _____

Workers Comp/ Motor Vehicle Information

Is this Visit related to a work injury? Yes or No

If work related: Employer Name: _____

Employer Phone Number: _____

Is this visit related to a motor vehicle accident? Yes or No

Assignment of Benefits

I sign directly to Integrity Health and Wellness all insurance benefits, if any, otherwise payable to me for services rendered. **I understand that I am financially responsible for all charges whether or not paid by insurance.** I authorize the use of the signature on all insurance submissions.

The above-named doctor may use my health care information and may disclose such information to the above insurance company(ies) and their agents for the purpose of attaining payment for services and determining insurance benefits payable for related services. This consent will end when my treatment plan is complete.

Signature of Beneficiary: _____

Please Print Name of Beneficiary: _____ **Date:** _____