MAXA INTERNAL MEDICINE ASSOCIATES, P.C.

3505 DULUTH PARK LANE
BUILDING 4, SUITE 400
DULUTH, GEORGIA 30096

RICHARD R. MAXA, M.D.

PATIENT INFORMATION

Last Name: ________________________________ First Name: ________________________ MI: _____

Address: ________________________________ City: _________________ State: _____ ZIP: ______

Social Security #: _______/______/_________ Date of Birth: ______/____/________ Sex: M / F Age: ______

Home Phone #: (________) ________–_________________ Cell Phone # (_______) _______– _________________

Marital Status: ________________________________ Spouse Name: ________________________________

Employer: ____ Work Phone: (______) _______–_____________

If under 18, Parent or Guardian: ____

Referred by: ____

In case of Emergency, contact: ______________________________ Work Phone: (______) _______–____________

INSURANCE INFORMATION

Primary Ins.: ________________________________ Policy #: ___________________ Group #: _________

Policy Holder Name: ____ Birth Date:: _____/___/_______

Secondary Ins.: ______________________________ Policy #: ___________________ Group #: _________

Policy Holder Name: ____ Birth Date:: _____/___/_______

INSURANCE AUTHORIZATION AND ASSIGNMENT

I hereby authorize the release of any information necessary to file a claim with my insurance company. I further authorize and direct my insurance company to pay the proceeds of any such claim directly to Maxa Internal Medicine Associates, P.C. (“MIMA”) and assign any right I may have to such funds to MIMA. In the event that I receive payment from my insurance company, I acknowledge that the funds belong to MIMA, and agree to promptly turn any such funds over to MIMA. I acknowledge and understand that I am personally responsible for all services rendered to me by MIMA, and that I am personally responsible for payment for any such services not covered by my insurance. I further acknowledge that no representations have been made by MIMA regarding any insurance coverage for services rendered or to be rendered and realize that any such coverage is controlled by whatever agreement I have with my insurance company. I further authorize MIMA to render treatment and/or medical advice for the betterment and well being of myself and/or my dependent.

Patient or Parent Signature: ____ Date: ____________________