

Hoyt W. Gazaway, M.D.
Buford Complete Health & Wellness Center

PLEASE PRINT

Patient's Full Name: _____

Mailing Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Email Address: _____

Date of Birth: ____/____/____ Age: ____ Sex: Male ____ Female ____

Social Security #: _____

Guarantor Name: _____

Address: _____

_____ City: _____ State: _____ Zip: _____

Employer: _____ Employer's Phone #: _____

Spouse Name: _____ Employer: _____ Phone: _____

Emergency Contact: _____ Phone: _____

INSURANCE INFO

Primary Insurance Co: _____

Insured Name: _____

Insured ID#: _____ Insured Group#: _____

Insured SS #: _____ Insured Birthdate: ____/____/____

Do you have a Co-pay? Yes No If Yes, what is it? _____

Secondary Insurance Co: _____

Insured Name: _____

Insured ID#: _____ Insured Group#: _____

Insured SS#: _____ Insured Birthdate: ____/____/____

Do you have any drug/environmental allergies? (please list) _____

Please list your medications: _____

Any chronic illnesses: _____

I hereby authorize the release of any medical information which may be required to process claims for payment of medical services to my insurance carrier, prepaid medical plan or Government Agency. When appropriate I authorize Assignment of surgical and/or medical benefits to Buford Complete Health and Wellness Center.

X _____ Date: _____