Peachtree Surgical Specialists, P.C.

Dr. Clarence R. Hixon, M.D., FACS

PATIENT INFORMATION

DATE: _____ Social Security #: _____

Name: _____ DOB: _____ Age: _____ Sex: **F M**

Parent/Guardian *(if patient is a minor)*: _____

Address: _____

City: _____ State: _____ Zip: _____ County: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Marital Status: **S M D W** Spouse Name: _____

Patient Employer: _____ *Occupation:* _____

Nearest Relative *(Not living with you):* _____ *Relationship:* _____ *Phone:* _____

EMERGENCY CONTACT: _____ *Relationship:* _____ *Phone:* _____

E-MAIL _____

MEDICAL INFORMATION

PRIMARY CARE PHYSICIAN: _____

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

Phone Number: _____ Fax Number: _____

RESON FOR VISIT: _____

Have you previously been seen by Dr. Clarence Hixon? Yes No *If yes, when:* _____

If yes, please state reason for visit: _____

_____

ALLERGIES? Yes No *If yes, please list:* _____

_____

MEDICATIONS? Yes No *If yes, please list:* _____

_____

INSURANCE INFORMATION

PRIMARY INSURANCE CARRIER: _____

Policy Holder Name: _____ Relationship to Insured: _____

Birth Date: _____ Place of Employment: _____ Phone: _____

Address of Insurance Company: _____ City: _____ State: _____ Zip: _____

Policy# / ID#: _____ Group#: _____

Benefits Phone#: _____ Precertification Phone #: _____

SECONDARY INSURANCE CARRIER: _____

Policy Holder Name: _____ Relationship to Insured: _____

Birth Date: _____ Place of Employment: _____ Phone: _____

Address of Insurance Company: _____ City: _____ State: _____ Zip: _____

Policy# / ID#: _____ Group#: _____

Benefits Phone#: _____ Precertification Phone #: _____

INSURANCE AUTHORIZATION

I understand that this release includes all confidential information in my medical record, including information related to psychiatric care, drug and/or alcohol abuse and HIV/AIDS. I authorize medical information to be released via Mail, Fax, Electronic Data, or by Telephone as requested. I understand that this authorization shall remain in effect until revoked by me in writing. I understand that I have the right to receive a copy of this authorization. I authorize all insurance benefits for services rendered by Peachtree Surgical Specialists, P.C. to be paid directly to Clarence R. Hixon, M.D. P.C.

Signature:	***Date:***