MEDICAL HISTORY Robert Gadlage, M.D., P.C.

Please Fill Out Completely:

Patient's Name: _____ SSN: _____

Date of Birth: _____ Age: _____ Referred By __ Friend/Relative __ Yellow Pages __ Newspaper Ad __ Physician _____

Patient's Address: _____ (Address) _____ (City) _____ (State) _____ (Zip)

Patient's Phone (Primary): ( ) _____ Other _____ Patient's Phone (Secondary): _____ Other _____

Marital Status: _____ (Married, Single, Divorced) Sex: [ ]M [ ]F (M,F) EMail address: _____

Employer: _____ Employer Phone: _____

Responsible Party: _____ Date of Birth: _____

Resp. Party Address: _____ (Address) _____ (City) _____ (State) _____ (Zip)

Resp. Party Phone: Primary _____ Secondary _____

Emergency Contact Name: _____ Emergency Contact Relationship: _____

Phone: _____ EMail address: _____

Referred By: _____

Is this visit related to a car accident? ☐ Yes ☐ No

Is this visit related to a work injury? ☐ Yes ☐ No

Date of Accident or Injury: _____

Employment:
☐ Employed Full-Time
☐ Retired
☐ Currently Unemployed

Primary Insurance Information

Primary Insurance Co.: _____ Sex: ☐ Male ☐ Female

Member Name: _____ Member ID No.: _____

Group Number: _____ Group Name: _____

Relationship: _____

SSN: _____ Date of Birth: _____

Secondary Insurance Information

Secondary Insurance Co.: _____ Sex: ☐ Male ☐ Female

Member Name: _____ Member ID No.: _____

Group Number: _____ Group Name: _____

Relationship: _____

SSN: _____ Date of Birth: _____

List Any Persons to Whom You Will Allow Access Of Your Medical Records

Name: _____ Relationship to Patient: _____

Name: _____ Relationship to Patient: _____

Medicare Lifetime Signature on File

I request that payment of authorized Medicare benefits be made on my behalf to Robert A. Gadlage, M.D., P.C. for any services furnished me by the physician. I authorize any holder of medical information about me to release to the Centers for Medicare and Medicaid Services and its agents any information to determine these benefits payable for related services.

Signature _____ Date _____

I understand terms are for services rendered. (If these terms create a problem, please see the business office about making other arrangements before you are examined.) I will be responsible for all charges incurred by me. Should collection proceedings become necessary, I agree to pay all costs of collection including a reasonable attorney's fee and waive all rights to claim personal property exempt under the laws of the state of Georgia. I hereby assign to and authorized payment directly to Robert Gadlage, M.D. All benefits payable under the terms of any insurance policy listed above if insurance is filed by the office. I realize the insurance benefits may not pay all of the bill and agree to pay the difference or the entire bill, if necessary. I authorize the release of any medical information necessary to process my insurance claims or to continue my medical care. I acknowledge that I have been provided access to notice of privacy practices of Robert Gadlage, M.D.

Signature _____ (Patient) Signature: _____ (Responsible Party) Date _____