



PATIENT INFORMATION

For the Facility checked below:

- HyperbaRXs at DeKalb (d.b.a. DeKalb Hyperbaric Medicine & Wound Care Center)
- HyperbaRXs at Johns Creek
- HyperbaRXs at Kennestone (d.b.a. Cobb Hyperbaric Medicine)
- HyperbaRXs at Northside Forsyth (d.b.a. North Georgia Center for Hyperbaric Medicine & Wound Care)
- HyperbaRXs at Saint Joseph's (d.b.a. Hyperbaric Medicine of North Atlanta)

Name: _____

Soc. Sec. #: _____ - _____ - _____

D.O.B.: _____

Age: _____

Marital Status: Single Married Divorced Widowed

Home Telephone: _____ - _____ - _____

Address: _____

Secondary Telephone: _____ - _____ - _____

E-mail Address: _____

Cellular Telephone: _____ - _____ - _____

Employer Name: _____

E-mail: _____

Employer Address: _____

Employer Telephone: _____ - _____ - _____

Primary Physician: _____

Referring Physician: _____

Primary Insurance: _____

Secondary Insurance: _____

Case Mgr. Telephone: _____ - _____ - _____

Guarantor: _____

Emergency Contact: _____

Contact's Relationship: _____

Contact's Telephone: _____ - _____ - _____

I authorize consultative services and related treatment by **HYPERBARIC PHYSICIANS OF GEORGIA**, this **FACILITY**, and its agents along with the releases of any necessary medical information needed in my care, or in the processing of medical claims to **HYPERBARIC PHYSICIANS OF GEORGIA**, this **FACILITY**, and its agents. I also request the payment of medical benefits for the care and services provided to **HYPERBARIC PHYSICIANS OF GEORGIA**, this **FACILITY**, and its agents.

I understand and agree to be responsible for the balance on my account for any professional/technical services rendered by **HYPERBARIC PHYSICIANS OF GEORGIA**, this **FACILITY**, and its agents. I certify that the information provided is true and correct to the best of my knowledge. I will notify **HYPERBARIC PHYSICIANS OF GEORGIA** and this **FACILITY** of any changes in the above information immediately.

(Signature of Patient)

(Date)

(Witness)