Albany ENT

Christopher J. Mann, M.D.-Magalie Nelson-Charles, M.D. -Stacey Parker, PA-C -Crystal Gay, PA-C – Julie Lambert, M.ED, CCC-A

Today's Date ____________________

Welcome to our office. We are anxious to make your visit as convenient as possible. Would you please help us by furnishing the information requested below? This will be used to complete your record and will be kept strictly confidential. Should you address change at any time, please notify our office.

Should you ever need to cancel an appointment, please call and let this office know as soon as possible. If you have any questions about your care, your appointment or our fees, please feel free to discuss them with us.

Patient's Name ____ Age _______ Birth Date ______________________

Sex __ M __ F SS# ______________________________ Marital Status __________

Address ____ City _________________ State ___ Zip__________

Res. Phone _______________________ **Cell Phone** _______________________ **Work Phone** _____________________

Email address _________________________________ Employed by ____

Pharmacy and Location __________________________________Referring Physician _________________________

Chief Complaint ____ Primary Care Physician______________________

Emergency Contact Information or other person to release medical information. *If patient is a child; please give both parents information.

Name ____ Relationship ___________________________________

Phone # ______________________________ SS #____________________________ Birthdate ____________________

Employer ______________________________________ Employer Phone # __________________________________

Name ____ Relationship_________________________________

Phone # ______________________________ SS #____________________________ Birthdate ____________________

Employer ______________________________________ Employer Phone # __________________________________

(1) **Insurance Co. Name/Address** _______________________________________ **Phone** _________________

Policy # _________________________ Group #___________________ Policy Holder __________________

(2) **Insurance Co. Name/Address** _____________________________________ **Phone** _________________

Policy # _________________________ **Group #**___________________ **Policy Holder** _________________

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Albany ENT or my insurance company to release any information required to process my claims.

Signature ____ Date ____

605 Pointe North Blvd, Albany, Georgia 31721 (229) 435-7161