VALDOSTA MEDICAL CLINIC
3207 COUNTRY CLUB DRIVE, VALDOSTA GEORGIA 31605

DR.REQUESTED ______________________ *ACCOUNT #* ______________________

WHO REFERRED YOU TO OUR OFFICE ______________________ *PATIENT IS A: MR MISS MRS MS*

LAST NAME ______________________ *FIRST NAME* ______________________ *MIDDLE* ______

AGE ________ *DATE OF BIRTH* ____________ *GENDER M / F RACE* ____________

REASON FOR APPOINTMENT ____

____

MEDICATION LIST ____

____

____

PHYSICIAN APPROVAL ____

STAFF TAKING INFORMATION ______________________ **DATE** ____________

SOCIAL SECURITY NUMBER ______________________ DO YOU SPEAK ENGLISH? YES NO

STREET ADDRESS ____

ZIP CODE __________ CITY ____________ STATE ____________ HOME # ____________

CELL # ______________________ WORK # ______________________

EMAIL ____

INSURANCE INFORMATION (1) PRIMARY ____

INSURANCE ADDRESS ____

ID # ON CARD ______________________ GROUP # ON CARD ______________________

INSURANCE PHONE # ______________________ INSUREDS NAME ______________________

*****DEDUCTIBLE AMT ________ PATIENT PAY AMT ________ INSURANCE VERIFICATION ________

INSURANCE INFORMATION (2) SECONDARY ____

INSURANCE ADDRESS ____

ID # ON CARD ______________________ GROUP # ON CARD ______________________

INSURANCE PHONE # LISTED ON CARD ______________ INSUREDS NAME ______________________

*****DEDUCTIBLE AMT ________ PATIENT PAY AMT ________ INSURANCE VERIFICATION ________

OTHER INFO ____