VALDOSTA MEDICAL CLINIC, 3207 COUNTRY CLUB DRIVE, VALDOSTA, GA, 31605

DR. REQUESTED____________________________________ACCOUNT#____

WHO REFERRED YOU TO OUR OFFICE____

LAST NAME_____________________________________FIRST NAME___________________________________MI________

DATE OF BIRTH:__ __ /__ __ /__ __ __ __GENDER________________PREVIOUS PCP_________________________________

REASON FOR APPOINTMENT____

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____

MEDICATION LIST____

____

____

PHYSICIAN APPROVAL____

____

STAFF TAKING INFOR____DATE:__ __ /__ __ /__ __ __ _

SOCIAL SECURITY NUMBER ___ ___ ___-___ ___-___ ___ ___ DO YOU SPEAK ENLGLISH:

STREET ADDRESS____

ZIP CODE___ ___ ___ ___ ___CITY____STATE_____________________

PHONE#: HOME:__ __ __-__ __ __-__ __ __ __CELL:__ __ __-__ __ __-__ __ __ __WORK:__ __ __-__ __ __-__ __ __ __

EMAIL____

PRIMARY INSURANCE____

INSURANCE ADDRESS____

MEMBER ID#_______________________________________GROUP#____

INSURANCE PHONE#:__-__ __ __-__ __ __-__ __ __ __ INSURED NAME____

DEDUCTIBLE AMOUNT$_____________PT PAY AMOUNT_____________INSURANCE VERIFICATION____________________

SECONDARY INSURANCE____

INSURANCE ADDRESS____

MEMBER ID#_______________________________________GROUP#____

INSURANCE PHONE#:__-__ __ __-__ __ __-__ __ __ __ INSURED NAME____

DEDUCTIBLE AMOUNT$_____________PT PAY AMOUNT_____________INSURANCE VERIFICATION____________________