Emmett Montgomery MD
Becky Montgomery MD

A TEAM APPROACH TO WELLNESS

BIRTH DATE _____/_____/_____ [ACCT/MED REC#_____]

LAST NAME_____FIRST_____MI_____

MAILING ADDRESS_____ HOME#:_____

HOME ADDRESS_____ CELL#:_____

CITY_____STATE_____ZIP_____

SS#_____-_____-_____ SEX: M F MARITAL STATUS: Married Single Divorced Widowed

EMERGENCY #:_____EMERGENCY NAME/RELATION:_____

EMAIL ADDRESS:_____

PATIENTS EMPLOYER:_____WORK#_____

EMPLOYERS ADDRESS:_____

*HOW WERE YOU REFERRED TO THIS OFFICE?_____

RESPONSIBLE PARTY ***(if patient under 18)***:_____RELATION TO PATIENT:_____

SS#:_____-_____-_____ SEX: M F BIRTH DATE: _____/_____/_____

ADDRESS:_____PHONE#:_____

CITY:_____STATE:_____ZIP:_____

RESPONSIBLE PARTY'S EMPLOYER:_____WORK#_____

EMPLOYER'S ADDRESS:_____

***Are you the primary insured for your policy? Y / N If NO,** INSURED'S NAME:_____

PRIMARY INSURANCE:_____POLICY/ID #:_____

GROUP#:_____ INSURED BIRTH DATE: _____/_____/_____ SEX: M F

INSURED'S ADDRESS:_____SS#_____-_____-_____

CITY_____STATE_____ZIP_____ INSURED'S PHONE#:_____

INSURED'S EMPLOYER:_____EMPLOYER'S PHONE#:_____

EMPLOYER'S ADDRESS:_____CITY:_____ST:____ZIP_____

***SECONDARY** INSURANCE:_____POLICY/ID #:_____*
(IF APPLICABLE)
***Are you the primary insured for this policy? Y / N** If NO, INSURED'S NAME:_____

GROUP#:_____ INSURED BIRTH DATE: _____/_____/_____ SEX: M F

INSURED'S ADDRESS:_____SS#_____-_____-_____

CITY_____STATE_____ZIP_____ INSURED'S PHONE#:_____

INSURED'S EMPLOYER:_____EMPLOYER'S PHONE#:_____

EMPLOYER'S ADDRESS:_____CITY:_____ST:_____ZIP_____

PLEASE READ AND SIGN BELOW

I hereby authorize Piedmont HealthCare/Advanced HealthCare (PHC/AHC) to release information concerning my medical or surgical treatment to any insurance carrier, including Medicare and Medicaid. I further authorize payment being made directly to PHC/AHC for my insurance benefits including major medical insurance. I understand that I am financially responsible to PHC/AHC for my charges and that the filing of insurance does not relieve me of this obligation. I further authorized any payment made by insurance companies that are incorrect to be refunded to the insurance company. I consent to x-ray examinations, laboratory procedures and other medical treatment as recommended by my physician as provided by authorized personnel of PHC/AHC. I also understand that PHC/AHC is not responsible for any of my personal or valuable items I bring with me.

Patient OR Guardian Signature: _____ ***Date:*** _____

Print Name: _____ ***Relation to Patient:*** _____