RALPH BOYNTON, PH.D.

1115 UPPER HEMBREE ROAD, STE. B
ROSWELL, GEORGIA 30076

PHONE: 404-663-5502
FAX: 770-475-1171

WELCOME TO OUR OFFICE

IN ORDER TO SERVE YOU PROPERLY, WE NEED THE FOLLOWING INFORMATION
ALL INFORMATION IS STRICTLY CONFIDENTIAL

DATE: _____
REFERRED BY: _____

PATIENT INFORMATION

NAME: First_____ Last:_____ MI:_____
ADDRESS: _____ CITY:_____ ZIP CODE:_____
SEX:_____ AGE: _____ BIRTHDATE: _____ MARITAL STATUS: _____
SOCIAL SECURITY # _____ HOME PHONE: _____
EMPLOYER: _____ WORK PHONE: _____

SPOUSE (OR PARENT) INFORMATION

NAME: First_____ Last:_____ MI:_____
EMPLOYER: _____
SOCIAL SECURITY # _____ WORK PHONE: _____
NEAREST RELATIVE: _____ RELATION: _____
ADDRESS: _____ PHONE: _____

INSURANCE INFORMATION

PRIMARY INSURANCE CARRIER: _____ GROUP # _____
POLICY # _____ INSURANCE PHONE _____
INSURED NAME: _____ INSURED EMPLOYER: _____

SECONDARY INSURANCE CARRIER: _____ GROUP # _____
POLICY # _____ INSURANCE PHONE _____
INSURED NAME: _____ INSURED EMPLOYER: _____

All professional services rendered are charged to the patient. Necessary forms will be completed to help expedite insurance carrier payment. However, the patient is responsible for all fees, regardless of insurance coverage. It is also customary to pay for services when rendered unless other arrangements have been made in advance. All appointments must be cancelled at least 24 hours in advance or the patient will be charged for that time slot.

SIGNED: _____

I authorize the release of any medical information necessary to process claims, and request that payment be made directly to the provider for any services rendered. I also understand if charges due to the provider are not collected, I will be responsible for payment.

SIGNED: _____