

ADVANCED SURGICAL GROUP OF NW GEORGIA, P.C.

MICHAEL J. O'REILLY, M.D.

All info on this form MUST be completed

Patient's First Name _____ Mid. Initial _____ LastName _____
Name Preferred _____ Date of Birth _____ Sex M F _____
Social Security Number _____ Marital Status _____
Mailing Address _____ Apartment _____
Zip Code _____ City _____ State, "-----:-----:-- --:--" _____
Home Ph () _____ WorRPh() _____ CellPh(). _____
Is the patient **amino.?** () _____

Primary Care / Referring Doctor First Name _____ LastName _____
Phone Number _____

Patient's Employer. _____
If Self Employed please list name of business and type of business _____
What is your spouse's name? _____
For info, what is your spouse's Social Security Number? _____ Date of Birth _____
Who can we contact in an emergency? _____
Relationship to patient _____ Phone No ()-----

What is your Primary Insurance? _____
Who is the INSURED on this insurance? _____
What is that person's date of birth? _____ Relationship to INSURED _____
What is the ID number? _____ Group Number _____
Specialist Co-pay Amount _____

What is your Secondary Insurance? _____
Who is the INSURED on this insurance? _____
What is that person's date of birth? _____ Relationship to INSURED _____
What is the ID number? _____ Group Number _____

If you have a **Third** Insurance please list the information here. _____

If the patient is a **minor**, who is the responsible party today? _____
Relationship to patient? _____ Phone No ()-----

I do hereby assign all medical and/or surgical benefits to which I am entitled, including all government and private insurance plans to this office. This assignment will remain in effect until revoked by me in writing. I understand that I am responsible for all my charges not paid by my insurance. I hereby voluntarily consent to my treatment at this office and authorize such treatments, examination, medications, anesthesia, surgical operations and diagnostic procedures (including, but not limited to the use of lab and radiographic studies) as ordered by my attending physicians. I have read this consent, am aware of its contents and fully understand the same. I acknowledge that no assurance or promises have been given to the patient concerning the results, which may be obtained by such treatments and procedures hereby, affirmed by the signature of the undersigned.

Patient or Guardian's Signature _____ Date _____