**PATIENT INFORMATION SHEET**

*Kennestone Family Medicine Sam Peng MD Irshad Syed MD*

|  |  |  |
| --- | --- | --- |
| First Name  **Patient Information Only** | Middle Name | Last Name |

|  |  |  |
| --- | --- | --- |
| Street Address City State Zip Code | | |
| Home Phone Number | Work phone Number | Cell Phone | |
| Date of Birth(mm/dd/yy) | Sex(M/F) | Social Security Number | |

|  |
| --- |
| Email |

|  |
| --- |
| Pharmacy Phone Address |
| Emergency Contact Name Phone Number | |

|  |  |
| --- | --- |
| Name of Employer | Occupation |

**Gardian/**

**Policy Holder**

|  |
| --- |
| If Patient is a minor(under 18 years old) and/or patient is not the primary insurance care holder, please complete the following: |

|  |  |  |
| --- | --- | --- |
| First Name | Middle Name | Last Name |

|  |  |
| --- | --- |
| Date of Birth(mm/dd/yy) | Relation to Patient |

CONSENT FOR TREATMENT and PAYMENT

I hereby authorize Dr.Peng /Dr.Syed or his associates to provide me with medical treatment. **I understand that I am ultimately responsible for all fees for services rendered.** I hereby authorize the release of any medical information necessary to file a claim with my insurance company.

Medicare/Insurance: I request that payment of authorized Medicare or Insurance benefits be made either to me or on my behalf to Dr.Peng / Dr.Syed or his associates furnished me by that physician. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits payable for related services. I hereby authorize Medicare to furnish to the above medical practice any information regarding my Medicare claims under Title XVIII of the Social Security Act.

I hereby volunteer consent to my treatment by Dr. Peng/ Dr.Syed or his associates at his office and authorize such treatments, examinations, medications and diagnostic procedures (including but not limited to the use of radiographic and laboratory studies) as ordered by attending physicians, **I understand that payment is due at the time of service and that I am responsible for any amount not paid by insurance.** I have read this consent, am aware of its contents and fully understand the same. I also understand that no assurance or promises have been given to me concerning the results which may be obtained by such treatment and/or procedures ordered by the attending physicians

Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_