Comprehensive Internal Medicine

3180 Northpoint Pkwy, Suite 303
Alpharetta, Georgia 30005

3890 Johns Creek Parkway Suite 120
Suwanee, Georgia 30024

Name: _____
First Middle Last

Sex: **Male / Female** **DOB:** _____/_____/_____ **SSN:** _____-_____-_____

Email: _____ **Home Phone:** _____

Mobile Phone: _____ **Work Phone:** _____

Address: _____

Apt. or Suite: _____ **City** _____**State:** _____ **Zip Code:** _____

Please circle below what categories you may fall under, you do have an option to defer.

Ethnicity: Hispanic/ Latino Non-Hispanic Native Hawaiian or other Pacific Islander Defer

Preferred Language: _____ **Defer** **Race:** _____ **Defer**

In Case of Emergency Notify: _____ **Relation:** _____ **Phone:** _____

Address: _____

Please list below your preferred Pharmacy Name, Location, Phone, and Fax Number:

_____

Please Choose a Primary Care Physician (circle): Dr. Pearson Dr. Bhushan Dr. Fatemi Dr. Bozof Dr. Carpenetti Dr. Hector

I authorize CIM to bill by insurance company for charges incurred during the course of treatment and to provide any medical information necessary to process insurance claims. I authorize payment to be made directly to CIM and a copy may be used instead of the original. I authorize my doctor to inquire about my account and to receive any information that may be necessary. I understand that CIM will file any claims with my insurance company for charges incurred. However, if my insurance company does not have a contract with CIM, I UNDERSTAND THAT I WILL BE PAYING FOR MY VISIT IN FULL. If my insurance company does have a contract with CIM, I agree that I will be responsible for all non-covered services and pre-existing conditions. I will be responsible for any co-payments and deductibles.

Patient's Signature/Guarantor's Signature (If patient is a minor):_____ **Date:** ____/____/____