Comprehensive Internal Medicine

3180 Northpoint Parkway, Suite 303
Alpharetta, Georgia 30005

390 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 decline.

Ethnicity: Hispanic/ Latino Non-Hispanic Decline

Preferred Language: ____________________ **Decline** **Race:** ____________________ **Decline**

In Case of Emergency Notify: ____________________ **Relation:** __________ **Phone:** __________

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

Address: ____

Phone: ____

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

How did you hear of our Practice?

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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:** _____/_____/_____