Account #__________________

COLUMBUS CARDIOLOGY ASSOCIATES, P.C.
2525 Williams ROAD
COLUMBUS, GA 31909

Alonzo E. Jones, M.D. ______ William Macheski, M.D. ______ John P. Byers, M.D. _____
Edward A. Matthews, D.O. ______ Mahesh N. Patel, M.D. ______ George Miller, M.D._____

REFERRED BY:______________________________ INITIAL VISIT DATE:_________________________

NAME:____
First Middle Initial Last

DATE OF BIRTH:_______________________ SOCIAL SECURITY _______________________________

HOME PHONE: ( )___________________________ WORK PHONE: ( )_____________________________

AGE:________________ SEX:________________ MARITAL STATUS:____________________________

HOME ADDRESS:____
City State Zip Code

EMPLOYER:_____________________________________ OCCUPATION:_______________________

WORK ADDRESS:____

SPOUSE'S NAME:_____________________________________ DATE OF BIRTH:__________________

SPOUSE'S SOCIAL SECURITY #:__________________________ OCCUPATION:__________________

SPOUSE'S EMPLOYER:_____________________________ WORK PHONE: ( )________________

WORK ADDRESS:____

NEAREST RELATIVE NOT LIVING WITH YOU:____

RELATIONSHIP:______________________________________ PHONE #: ( )____________________

PERSON TO CONTACT IN CASE OF EMERGENCY:____

RELATIONSHIP:___________________________ PHONE #:_____________________________________

HAVE YOU SEEN ANY OF THE DOCTORS IN THIS PRACTICE BEFORE? YES / NO

PLEASE READ AND SIGN: I authorize any holder of medical or other information about me to release to the Social Security Administration and Health Care Financing Administration or its intermediates or carriers any information needed for this or a related Medicare/Insurance claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical pertaining to Medicare assignment of benefits apply. This authorization applies to other health coverage I have.

SIGNATURE:____

DATE:_____________________________

*** Payment is requested at Time of Service. *** ***Thank you***