Atlanta Medical Arts and Wellness, LLC

Patrice Y. Marshall, M.D.
2784 N. Decatur Road, Suite 100
Decatur, Georgia 30033
(404) 719-5999 (Main)
(404) 719-5998 (Fax)

DEMOGRAPHIC FORM

Please complete all fields, if the field does not apply, please enter N/A.

Date _____

PATIENT INFORMATION

Patient: Last_____ First_____ Middle_____ Preferred name_____

Address: Street _____ City_____ State_____ Zip Code_____

Home phone: _____ **Mobile phone:** _____**Alternate phone:** _____

Social Security Number: _____ **Date of Birth**: _____ **Gender at Birth:** _____

Gender Identity: Male ___ Female ___ Non-Binary ___ **Preferred Pronouns** _____ **Race:** _____

Marital Status: Single ___ Married ___ Domestically Partnered ___ Divorced ___ Widowed ___ Separated _____

Spouse's/Partner's Name: _____**Allergies:** _____

Employer: _____ **Work Number:** _____

Address: Street _____ City_____ State_____ Zip Code_____

Occupation: _____

Email Address: _____

RESPONSIBLE PARTY (IF OTHER THAN PATIENT)

Name: Last_____ First_____ Middle_____

Address: Street _____ City_____ State_____ Zip Code_____

Home phone: _____ **Mobile phone:** _____ **Alternate phone:** _____

Date of Birth: _____**Social Security Number:** _____ **Driver's License Numb**er: _____

Employer: _____ **Work Number:** _____

Address: Street _____ City_____ State_____ Zip Code_____

Occupation: _____

Atlanta Medical Arts and Wellness, LLC

Patrice Y. Marshall, M.D.
2784 N. Decatur Road, Suite 100
Decatur, Georgia 30033
(404) 719-5999 (Main)
(404) 719-5998 (Fax)

(Continued)

INSURANCE INFORMATION

Primary Insurance: _____ Policy number: _____ Group Number: _____

Address: Street _____ City_____ State_____ Zip Code_____

Insured's name: _____ Date of Birth: _____

Secondary Insurance: _____ Policy number: _____ Group Number: _____

Address: Street _____ City_____ State_____ Zip Code_____

Insured's name: _____ Date of Birth: _____

EMERGENCY CONTACT

Name: _____ Relationship: _____

Address: Street _____ City_____ State_____ Zip Code_____

Home phone: _____ **Mobile phone:** _____**Alternate phone:** _____

Who can we thank for referring you to us? _____

I understand the office will file all insurance claims and work with the insurance company to insure payment for services rendered in the office. However, should my insurance company deny my claim, I understand that I am financially responsible for these services.

Patient or responsible party signature: _____ Date: _____