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☐ David H. Jacobson, M.D., F.A.C.E.
☐ Darwin L. Brown, M.D.
☐ Jay B. Mepani, M.D.

Diabetes & Endocrinology Associates, P.C.
2665 N. Decatur Rd. #620 Telephone: (404) 299-2223
Decatur, Georgia 30033 Facsimile: (404) 297-5003

Last Name:	First Name:	Initial:	Date of Birth:	Patient Number:		Date:

Patient Address

Street address
Apt number
City
State
Zip

Patient Telephone

Telephone (home)	(____) _____–_________
Telephone (work)	(____) _____–_________
Telephone (mobile)	(____) _____–_________
Fax	(____) _____–_________
Other	(____) _____–_________

Physician Information

Which physician are you here to see?
Who referred you to this practice?
Who is your primary care physician?
Have you ever seen any other doctor in this practice?
What is the primary medical problem leading to this visit?

Patient Information

Social Security number _______–_____–_________
Birth date Age
Sex ___M ___F Race _____Black _____Hispanic _____Asian _____Native American _____White
Marital status _____single _____married _____divorced _____other
Employer
Employment status ___full-time ___part-time ____retired ___not employed

Spouse/Parent Information

Name
Social Security number _______–_____–_________
Birth date Age
Employer
Employment status ___full-time ___part-time ____retired ___not employed
Telephone number (work) (_______) _______–___________

Billing Information

Name of the person responsible for the bill
Address
City, State, Zip
Telephone number (home) (_______) _______–___________
Telephone number (work) (_______) _______–___________
Employer

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Primary Insurance Information

Insurance company name	Telephone number (______)
Insurance company address	
City, State, Zip	
Subscriber name	relationship to patient
Policy or ID number	
Group number	
Social security number ________–______–__________	
Effective date	
Does your insurance require a co-pay?	amount $__________
Does your insurance have a deductible?	amount $__________

Secondary Insurance Information

Insurance company name	Telephone number (______)
Insurance company address	
City, State, Zip	
Subscriber name	relationship to patient
Policy or ID number	
Group number	
Social security number ________–______–__________	
Effective date	
Does your insurance require a co-pay?	amount $__________
Does your insurance have a deductible?	amount $__________

Payment is Expected at the Time of Service

I plan to pay by: ___cash ___check ___credit card (MasterCard Visa Discover)

Emergency Notification

Person to notify in the event of emergency	relationship to patient
Address	
City, State, Zip	
Telephone (home) (______)______–__________	
Telephone (work) (______)______–__________	

I authorize the release of any medical information necessary to process insurance claims.

Patient or authorized person's signature________________________________ Date______________

I authorize payment of medical benefits to the above named physicians

Patient or authorized person's signature________________________________ Date______________