

High Mountain Healthcare

T. Michele Thompson, MD Cynthia J. Libert, MD Dinah M. Conti, MD  
Suzanne L. Nunn MD PC, Tiffany Rouse, PA, Steven Rouse, PA  
P.O. BOX 2239  
BLAIRSVILLE, GA 30514

PATIENT INFORMATION SHEET

Patient's Last Name \_\_\_\_\_ First \_\_\_\_\_ Middle Initial \_\_\_\_\_

Mailing Address \_\_\_\_\_ City/State/Zip \_\_\_\_\_

Hm Phone(\_\_\_\_) \_\_\_\_\_ Wk Phone(\_\_\_\_) \_\_\_\_\_ Cell(\_\_\_\_) \_\_\_\_\_

Birthdate \_\_\_\_\_ Soc. Sec. Nbr. \_\_\_\_\_ Male \_\_\_\_\_ Female \_\_\_\_\_

E-Mail \_\_\_\_\_ Marital Status: M S D W Employed by: \_\_\_\_\_

Employer's Address \_\_\_\_\_ City/State/Zip \_\_\_\_\_

**IF PATIENT IS A CHILD OR DEPENDENT, PLEASE COMPLETE THE FOLLOWING:**

Responsible Party's Name: \_\_\_\_\_ RELATION TO PATIENT \_\_\_\_\_

Mailing Address \_\_\_\_\_ City/State/Zip \_\_\_\_\_

Hm Phone(\_\_\_\_) \_\_\_\_\_ Wk Phone(\_\_\_\_) \_\_\_\_\_ Cell(\_\_\_\_) \_\_\_\_\_

Birthdate \_\_\_\_\_ Soc. Sec. Nbr. \_\_\_\_\_ Male \_\_\_\_\_ Female \_\_\_\_\_

E-Mail \_\_\_\_\_ Marital Status: M S D W Employed by: \_\_\_\_\_

Employer's Address \_\_\_\_\_ City/State/Zip \_\_\_\_\_

**PLEASE GIVE YOUR INSURANCE CARDS AND DRIVER'S LICENSE WITH THIS FORM TO SCAN:**

Primary Insurance Company Name \_\_\_\_\_

Secondary Insurance Company Name \_\_\_\_\_

Third Insurance Company Name \_\_\_\_\_

**IF INSURANCE HOLDER IS DIFFERENT FROM PATIENT:** \_\_\_\_ If same as responsible party If not, please complete

Insurance Holder's Name \_\_\_\_\_ Relation to patient \_\_\_\_\_

Mailing Address \_\_\_\_\_ City/State/Zip \_\_\_\_\_

Hm Phone(\_\_\_\_) \_\_\_\_\_ Wk Phone(\_\_\_\_) \_\_\_\_\_ Cell(\_\_\_\_) \_\_\_\_\_

Birthdate \_\_\_\_\_ Soc. Sec. Nbr. \_\_\_\_\_ Male \_\_\_\_\_ Female \_\_\_\_\_

E-Mail \_\_\_\_\_ Marital Status: M S D W Employed by: \_\_\_\_\_

Employer's Address \_\_\_\_\_ City/State/Zip \_\_\_\_\_

**EMERGENCY CONTACT (someone who does not live with you):**

Name \_\_\_\_\_ Relationship \_\_\_\_\_

Address \_\_\_\_\_ City/State/Zip \_\_\_\_\_

Hm Phone(\_\_\_\_) \_\_\_\_\_ Wk Phone(\_\_\_\_) \_\_\_\_\_ Cell(\_\_\_\_) \_\_\_\_\_

I certify that the above information is correct. I understand the office financial policies and procedures. I understand that High Mountain Healthcare reserves the right to add a 10% collection fee and any additional attorney fees that may apply to my account if it is forwarded to a collection agency.

Patient Signature: \_\_\_\_\_