BEN HOGAN M.D.
Phone: (229) 333-0616
Fax: (229) 333-0647

Family Practice and Sports Medicine
117 W. Northside Drive
Valdosta, GA 31602

NEW PATIENT INFORMATION

PLEASE PRINT

Name: _____ ☐ Home Phone:_____

Date of Birth: _____ ☐ Work Number: _____

Social Security Number: _____ ☐ Cell Number: _____

☐ Billing Address: _____

City: _____ State: _____ Zip Code: _____

Sex: Male ☐ Female ☐

Single ☐ Married ☐ Widowed ☐ Divorced ☐ Separated ☐

Place of employment: _____

Phone number: _____

In case of emergency, notify: _____ Phone: _____

Pharmacy Name: _____

Whom may we thank for referring you? _____

INSURANCE INFORMATION

WE WILL RETAIN INSURANCE INFORMATION FROM A COPY OF YOUR CARD

NAME OF INS.:_____ **SELF-PAY:** _____

ID NUMBER: _____ **COPAY: $** _____

I, the undersigned, (or my dependent(s)) certify that have insurance coverage as stated above and do assign directly to Dr. Ben Hogan all benefits, if any, otherwise payable to me the services rendered. I understand that I am financially responsible for all charges whether or not paid by my insurance. I hereby authorize the Doctor to release all information necessary to secure the payments of benefits. I authorize the use of this signature on all insurance submissions; furthermore, I understand that if my account requires collection by an outside agency I will be responsible for any cost incurred to collect payment in full.

Responsible Party Signature: _____ Date: _____

Relationship to Patient: _____