TOTAL CARDIOLOGY OF ATLANTA

2801 North Decatur Road, Suite 395
Decatur, GA 30033

F. Michael Toca, M.D.

Office (678) 995-5068
Facsimile (470) 575-5849

PATIENT INFORMATION – PLEASE PRINT

NAME (Last, First, Middle)	SSN#	BIRTHDATE	SEX

Local Address APT#	CITY, STATE ZIP

HOME PHONE	CELL PHONE	EMAIL

EMERGENCY CONTACT NAME	TELEPHONE NUMBER	RELATIONSHIP TO PATIENT

PRIMARY EMPLOYER	WORK PHONE

ADDRESS	CITY, STATE ZIP

RESPONSIBLE PARTY INFORMATION (If Different than above)

NAME (Last, First, Middle)	SSN#	BIRTHDATE	SEX

LOCAL ADDRESS	CITY, STATE ZIP	SECONDAY/BILLING ADDRESS (If Applicable)

HOME PHONE	CELL PHONE	PREFERRED PHONE	CITY, STATE, ZIP

EMPLOYER	RELATIONSHIP TO PATIENT

PRIMARY INSURANCE

NAME OF INSURANCE COMPANY	POLICY#

NAME OF INSURED	GROUP#

ADDRESS OF INSURANCE COMPANY	COPAY AMT
	$

CITY, STATE, ZIP	PHONE	DEDUCTIBLE
		$

RELATIONSHIP TO PATIENT	EFFECTIVE DATE	EXPIRATION DATE

SECONDARY INSURANCE (If Applicable)

NAME OF INSURANCE COMPANY		POLICY#	
NAME OF INSURED		GROUP#	
ADDRESS OF INSURANCE COMPANY		COPAY AMT	
CITY, STATE, ZIP	PHONE	DEDUCTIBLE	
RELATIONSHIP TO PATIENT		EFFECTIVE DATE	EXPIRATION DATE

PRIMARY CARE PROVIDER INFORMATION

NAME OF COMPANY		PROVIDER NAME
ADDRESS		
CITY, STATE, ZIP	PHONE	FAX

REFERRING PROVIDER INFORMATION

NAME OF COMPANY		PROVIDER NAME
ADDRESS		
CITY, STATE, ZIP	PHONE	FAX

I authorize the release of any medical or other information necessary to process this claim, including information related to AIDS, Mental Health, and Substance Abuse. I authorize payment of medical benefits to the physician or supplier for all services rendered. I understand and agree that regardless of my insurance status, I am ultimately responsible for the balance of my account for any professional services rendered. I understand and agree there is an 30% added to my balance once past due balance is sent to collections.

SIGNATURE OF PATIENT/GUARDIAN

DATE