Dr. Jesse Moskowitz **General Surgeon**

Phone 229.896-8520
Fax 229.896.8523

407 N. Parrish Avenue
Adel, Ga 31620

Last Name: __________________________ First Name: _______________________ Middle________________

Address: ____City: ____________State: ___________ Zip:_________

Home Phone: ______________________ Date of Birth: ____________ Soc. Sec. No.: _________________

Marital Status: ❑ Single ❑ Married ❑ Divorced ❑ Widowed Race: __________________

Employer: _____________________________________ Employer Address: ___________________________

Work Phone___________________ ❑ Full Time ❑ Part Time

Occupation: _____________________________ Maiden Name: _____________________________________

If the patient above is under 18 years of age, the following must be completed by the patient's parent or guardian.

Last Name: _______________________________ First Name: ____________________ Middle: ___________

Address: ____ City_____________ State___________ Zip_________

Home Phone: ______________________ Date of Birth: ____________ Soc. Sec. No.: _________________

Work Phone___________________ ❑ Full Time ❑ Part Time

Occupation: _____________________________ Maiden Name: _____________________________________

Relationship To the Patient: ____

Person to notify in case of emergency: Name: ____

Phone Number: _______________________________ Relationship to Patient _________________________

Insurance Information:

Do you have insurance of any kind? ❑ Yes ❑ No

Name of Insurance Company: ____

Policy Number: _________________________________ Group Number: _______________________________

Please give your insurance card to the receptionist to be copied.

Assignment of Insurance Benefits
I hereby authorize direct payment of surgical/medical benefits to Dr. Jesse Moskowtiz for services rendered by him in person or under his supervision. I understand that I am financially responsible for any balance not covered by my insurance.
Medicare-Medicaid
I certify that the information given by me in applying for payment is correct. J I request that payment of aurthoized benefits be made on my behalf.

HIPAA Notice of Privacy Practices
I certify that I have received a copy of the HIPAA Notice of Privacy Practices.
Patient Name: (Please Print) ___________________________________ Date: ____________________ Patient/Guardian: (Please Print) _____________________________ Signature: ___________________