Gregory J. Mackay, MD, PC
Donald R. Nunn, MD
M. Susann Bedford, MD
5673 Peachtree Dunwoody Road, NE Suite 870
Atlanta, GA 30342

Today's Date_____

_____ _____ _____
Last Name First Name Middle Name

_____ _____
Patient's Social Security Number Patient's Date of Birth

_____
Street Address

_____
City, State, Zip

_____ _____ _____
Home Phone Work Phone Cell Phone

_____S_____M_____D_____W _____
Spouse's Name

_____ _____
Patient's Employer Employer's Address

_____
E-Mail Address
****

_____ _____ _____
Emergency Contact Relationship Phone Number

_____ _____
Responsible Party if Other than Patient Relationship to Patient

I herby authorize Gregory J. Mackay M.D., M. Susann Bedford, M.D., and/or Donald R. Nunn, M.D. to bill my insurance carrier if applicable for any services rendered by him or any agents of his practice. With this authorization, I assign any and all benefits payable for services rendered by Gregory J. Mackay, M.D., M. Susann Bedford, M.D., and/or Donald R. Nunn, M.D.. I understand that I am responsible for any amount not covered by my insurance plan. I hereby authorize the release of any and all medical information necessary to the treatment I will receive while under the care of Gregory J. Mackay M.D., M. Susann Bedford, M.D., and/or Donald R. Nunn, M.D.. I authorize the release of medical information including x-rays, pathology, laboratory and operative reports. A copy of this authorization shall be valid as the original.

_____ _____
Patient's Signature Date