ORTHOPAEDIC ASSOCIATES

Doctor:_____ **Patient ID#:**_____

PATIENT INFORMATION

Name: _____ Sex: [ ]M [ ]F Date of Birth: _____Age: _____

Address: _____ Social Security #: _____

_____ Marital Status: [ ] Married [ ] Single Race: [ ] White [ ] Black

City, State, Zip: _____ [ ] Divorced [ ] Widowed [ ] Hispanic [ ] Other

Phone: _____[ ] Home [ ] Work [ ] Cell Referring Physician: _____

Phone: _____[ ] Home [ ] Work [ ] Cell Primary Care Physician: _____

EMERGENCY CONTACT Name Relationship Phone

_____

PATIENT'S EMPLOYMENT INFORMATION [ ] Employed [ ] Retired [ ] Student [ ] Other

Employer / School: _____ Employer / School Phone: _____

Employer Address: _____ City, State, Zip:_____

GUARANTOR INFORMATION [ ] Same as Patient

Relationship to Patient: _____

Name: _____ Employer: _____

Address: _____ Phone: _____ [ ] Home [ ] Work [ ] Cell

_____ SSN: _____

City, State, Zip: _____ Date of Birth: _____

PRIMARY INSURANCE INFORMATION

[ ] Health [ ] Liability [ ] Other

Insured Party: _____

Insured Phone: _____

Relationship to Patient:: _____

Social Security #: _____

Insured's Date of Birth: _____

Insured's Employer: _____

Insurance Company: _____

Insured's ID: _____

Policy Group #: _____

SECONDARY INSURANCE INFORMATION

[ ] Health [ ] Liability [ ] Other

Insured Party: _____

Insured Phone: _____

Relationship to Patient: _____

Social Security #: _____

Insured's Date of Birth: _____

Insured's Employer:_____

Insurance Company: _____

Insured's ID: _____

Policy Group #: _____

WORKERS COMPENSATION INFORMATION Mail Claims To: [ ] Insurance Carrier [ ] Employer

Insurance Carrier Name: _____ Phone: _____Contact Person: _____

Address: _____ Claim #: _____

City, State, Zip: _____ Employer at Time of Injury: _____

I authorize ORTHOPAEDIC ASSOICATES to perform treatment deemed by the physician in exercise of professional judgment to be of appropriate kind and method on me / my dependent. I hereby authorize ORTHOPAEDIC ASSOCIATES to release any information acquired in my examination or treatment to any insurer, government agency providing benefits, or to anyone for charges.

SIGNED X_____ DATE _____

I hereby assign to and authorize payment to ORTHOPAEDIC ASSOCIATES all benefits payable under the terms of any insurance policy listed above. I realize the insurance, workers compensation and / or liability claims may not pay the entire bill. I agree to pay the difference or the entire bill if necessary. I also agree to pay costs of collection, including attorney's fees and waive my exemption under the constitution and laws of the state of Georgia.

SIGNED X_____DATE _____