# Patient Information

**ATLANTA HAND SPECIALIST/ATLANTA HAND THERAPY**
(770) 333-7888 • (678) 214-6960

Last name: ________________________________________First Name: ________________________________MI:_______

Address: ______________________________________________________________________Apt #: _________________

City: _____________________________________________State: _____________________Zip: _____________________

Date of Birth: _________/________/___________ PATIENT'S Social Security #: __________/________/______________

Home Phone #: ______________________________Work #: ______________________Cell #: _______________________

Male_____Female_____ **Marital Status:** Single _____Married_____ Spouse's Name: ____________________________

EMERGENCY Contact: __________________________________________Phone #:_________________________________

Is the injury related to an auto accident? Yes_____ No______

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**Current Employer/School:** ________________________________________________________________________

Address: _____________________________________ City: ___________________________State: ______Zip: __________

Employer's/School Phone #: _________________________________Occupation: __________________________________

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**Name of Parent/Guardian (if under 18):** _____________________________________________________________

Address: __________________________________________ City: ______________________State: ______Zip: __________

Work Phone #: ______________________________________ Social Security #: ___________/_______/______________

Parent/Guardian's Employer: __________________________________________________________________________

Nearest Relative/Friend Not Living With You: ______________________________Phone #:_________________________

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**Referring Physician/Facility:** ___________________________________________Phone #: __________________________

Address: _________________________________________ City: ______________________State: ______Zip: ___________

**Primary Care Physician:** ______________________________________________Phone #: ___________________________

Address: _________________________________________ City: ______________________State: ______Zip: ___________

**Preferred Pharmacy:** ___________________________________________________ Ph#:____________________________

X___________________________________________________________ _________________________

**Patient's/Parent's/Guardian's Signature** **Date**

**How did you hear about us?** Magazine____ Radio ____ Internet____ Friend/Family____ Our Website____
Other (list) _________________________________________________________

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3968 Felton Hill Road, SW • Suite 100 & 220
Smyrna, Georgia 30082

3903 South Cobb Drive • Suite 200
Smyrna, GA 30080

6025 Professional Pkwy. • Suite 200
Douglasville, GA 30134

# Insurance Information (page 1 of 2):

WE WILL NEED YOUR CURRENT INSURANCE CARD(S) AND YOUR DRIVER'S LICENSE.

Patient's Name: ________________________________________________________________

***Subscriber =** The individual who is responsible for payment of premiums or whose employment is the basis for eligibility for membership in a group health plan.*

** **If the patient is the subscriber, then only complete the first 2 lines. ****

**(1) Primary Insurance:** ________________________________________________________ Phone#:_______________________________

Subscriber's Insurance ID #: ___________________________________________Group #: _______________________________________

SUBSCRIBER's Name: _______________________________________________Social Security #: _________/__________/____________

Date of Birth: _________/_________/___________Relationship to Patient: __________________________________________________

Authorization/Referral Required: Yes No

Subscriber's Employer: ________________________Address: ________________________________________ State: _____Zip: ____________

**(2 )Secondary Insurance (if applicable):** ________________________________________________Phone#:_____________________________

Subscriber's Insurance ID #: _____________________________________________Group #: ________________________________________

SUBSCRIBER's Name: ___________________________________________Social Security #:__________/_________/________________

Date of Birth: _________/__________/___________Relationship to Patient: _______________________________________________

Authorization/Referral Required: Yes No

Subscriber's Employer: __________________________Address: ________________________________________ State:_____Zip:___________

**(3) Tertiary Insurance (if applicable):** _____________________________________________________Phone#:__________________________

Subscriber's Insurance ID #: _____________________________________________Group #: ________________________________________

SUBSCRIBER's Name:____________________________________________ Social Security #: __________/_________/___________

Date of Birth: _________/_________/____________ Relationship to Patient: ____________________________________________

Authorization/Referral Required: Yes No

Subscriber's Employer: ________________________Address: ________________________________________ State: ______ Zip: ____________

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**Workers' Compensation/Liability Insurance Company:** ______________________________________________Date of Injury: ___________________

Address: ____________________________________________________City: _________________________State: ________ Zip: _____________

Claims Adjuster's Name: _________________________________________________________Claim #: __________________________________

Phone #: ________________________________________________________Fax #:__________________________________________________

Employer at Time of Injury: _________________________________________________Occupation: __________________________________

Employer's Address: __________________________________________City: _________________________State: ______ Zip: _______________

Supervisor's Name: ___________________________________Phone#:________________________ Years employed in this position: ________

In the event that the bills should be sent to an address other than the worker's compensation insurance company listed above, please complete the next page.

X____________________________________________________ _____________________________________

Signature of patient/parent/guardian/responsible party Date

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## Insurance Information (page 2 of 2):

Patient's Name: ____________________________________________________________

In the event that the bills should be sent to an address other than the workers' compensation insurance company listed on the previous page, please complete the following:

Name of Company: ____ ______________________________________________________________

Attention: ______________________________________________________________

Address: ______________________________ City: ______________________State: ______ Zip: __________

Phone #: ______________________________ Fax #: ______________________________________

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**Referrals (if applicable):** I understand my insurance company will not pay the physician/provider or reimburse for the cost of today's services without a referral and that I am responsible for payment of the office visit charge or any other charge I may incur.

**Co-pays (if applicable):** I understand that co-pay amounts are part of the agreement I have with the insurance company and are due at the time of the visit and that I am responsible for that payment.

**Authorization to pay benefits to the physician/provider:** I hereby authorize payment directly to the physician/provider for surgical and/or medical benefits, if any, otherwise payable to me for services as described, realizing I am responsible to pay non-covered services.

**Authorization to release information:** I hereby authorize the physician/provider to release any information acquired in the course of my treatment necessary to process insurance claims and/or for insurance audit purposes.

**Collection:** Within 90 days after being billed for services performed by the Atlanta Hand Specialist. I promise to pay in full the charges for those services personally, whether or not I have a claim against third parties for the cost of these services. I will also be responsible for any additional charges incurred in the collection of my account.

**X** ____________________________________ ______________________________

Signature of patient/parent/guardian/responsible party Date

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**Authorization to release information to your attorney:**

**Complete this section to allow release of information to your attorney if he is representing you for this problem.**

Attorney's Name: ______________________________________________________________

Address: ______________________________________________________________

City: ____________________________________State: ____________________Zip: _____________

Phone #: ______________________________ Fax #: ______________________________________

**I hereby authorize complete release of information to the above named attorney:**

**X** ____________________________________ ______________________________

Signature of patient/parent/guardian/responsible party Date