INTERNAL ACCT# _____

PREMIER ORTHOPEDICS, PC

Doctor / Provider Name: _____ Today's Date: _____

How did you hear about our office? ☐ TV ☐ Newspaper ☐ Dr. Referral ☐ Friend / Family ☐ Internet/Website ☐ Yellow Pages ☐ Other

Primary Care Physician: _____ PCP City & State: _____ PCP Phone Number: _____

Referral Source: _____ Premier Patient ID # (office use only): _____

Date symptoms/injury first appeared: ___/___/___ Is this an auto accident claim? ☐ Yes ☐ No Is this a work-related injury? ☐ Yes ☐ No

Is the visit due to an injury? ☐ Yes ☐ No If Yes, how did the injury occur? _____

PATIENT INFORMATION

Date of Birth: ___/___/___ Age: _____ Social Security Number: _____

Full Name: _____ (Last) _____ (First) _____ (Middle) Preferred: _____

Physical Street Address: _____ City, State: _____ Zip: _____

Mailing Address (if different than physical): _____ City, State: _____ Zip: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Employer: _____ Occupation: _____ May we contact you at work? ☐ Yes ☐ No

Patient's Spouse Name: _____ Emergency Contact: _____ Emergency Phone: _____

Gender: ☐ Male ☐ Female Marital status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed Number of children: _____

Race: ☐ Caucasian ☐ Black / African American ☐ Hispanic ☐ Asian ☐ American Indian ☐ Indian ☐ Native American ☐ Alaska Native

Ethnicity: ☐ Non-Hispanic ☐ Hispanic ☐ Other _____ Language: ☐ English ☐ Spanish ☐ Other _____

Please indicate where you may be reached during business hours: ☐ Home ☐ Work ☐ Cell Phone

May we contact you at home? ☐ Yes ☐ No

If calling your home, leave a message with:

☐ Yes ☐ No Voicemail / Answering Machine
☐ Yes ☐ No Mobile / Cell Phone
☐ Yes ☐ No Family Member / Friend
If so, who? _____

May we contact you at your place of business? ☐ Yes ☐ No

If calling your home, leave a message with:

☐ Yes ☐ No Voicemail / Answering Machine
☐ Yes ☐ No Mobile / Cell Phone
☐ Yes ☐ No Family Member / Friend
If so, who? _____

May we contact you via email? ☐ Yes ☐ No If yes, please list the preferred email address: _____

RESPONSIBLE PARTY

Person responsible for billing: ☐ Self ☐ Spouse ☐ Parent ☐ Employer ☐ Other _____ Relationship to patient: _____

Insured Name: _____ Date of Birth: _____ Social Security Number: _____

Street Address: _____ City, State: _____ Zip: _____

Home Phone: _____ Work Phone: _____ Ext: _____

Employer: _____ Occupation: _____

Street Address: _____ City, State: _____ Zip: _____

PRIMARY INSURANCE COVERAGE

Insured Policyholder's Name (if other than patient): _____ Address: _____

Date of Birth: _____ Home Phone: _____ Work Phone: _____

Employer Name: _____ Occupation: _____ Social Security Number: _____

Insured Group Number: _____ Policy Number: _____

SECONDARY INSURANCE COVERAGE

Insured Policyholder's Name (if other than patient): _____ Address: _____

Date of Birth: _____ Home Phone: _____ Work Phone: _____

Employer Name: _____ Occupation: _____ Social Security Number: _____

Insured Group Number: _____ Policy Number: _____

MEDICARE & MEDICAID COVERAGE

Medicare Part A #: _____ Effective Date: _____

Medicare Part B #: _____ Effective Date: _____

Medicaid Number: _____ Issuing State: ☐ Georgia ☐ Other: _____

INDUSTRIAL INJURY (WORKERS COMP)

Date of Injury: _____ Date Injury Report Filed: _____

Employer at the Time of Accident: _____ Employer Phone: _____

Employer Mailing Address: _____ City, State: _____ Zip: _____

Injury Authorized to Treat: _____ Contact Person: _____

AUTO ACCIDENT / THIRD PARTY

Date of Accident: _____ Name of Representing Attorney: _____

Policy Holder's Name: _____ Relationship to Patient: _____

Insurance Company responsible for Medical Bills: _____

Insurer Mailing Address: _____ City, State: _____ Zip: _____

Insurance Claim Number: _____ Agent/Adjuster Name: _____ Phone Number: _____

AUTHORIZATION & ASSIGNMENT OF BENEFITS

I hereby authorize Premier Orthopedics, PC to release information concerning my illness and treatments to insurance companies, attorneys, other physicians, and/or other specific interested parties. I hereby assign to the physicians all payments for medical services to my dependents or myself. I understand that I am responsible for any balance not paid by my insurance or third party. I understand that a copy of this authorization shall and may be treated as an original. Patient does hereby consent to the rendering of medical care and treatment, which may include diagnostic testing procedures and such treatment and care as considered necessary or appropriate by the rendering physician.

Signature of Patient: _____ Date: _____

Signature of Parent / Guardian: _____ Date: _____