AUGUSTA ORTHOPEDIC & SPORTS MEDICINE SPECIALISTS, P.C.

PATIENT INFORMATION FORM

Please complete entire form

Name (First, M.I., Last): _____

Address: _____

City _____ State _____ Zip _____

Phone #: _____ Cell #: _____ Social Security #: _____

Date of Birth: _____ Age: _____ Sex: Male/Female Marital Status: S M W D

Employer: _____

Work #: _____ Patient Email Address: _____

If Student, School Name: _____ Full/Part Time

RESPONSIBLE PARTY

Name: _____

Relationship to Patient: _____

Phone #: _____ Work #: _____

Responsible Party Email Address: (must be different from patient email) _____

EMERGENCY CONTACT INFORMATION

Name: _____

Relationship to Patient: _____

Phone #: _____

Work #: _____

Primary Insurance Co. Name _____

Name of Insured _____ SS # _____ DOB _____

Policy # _____ Group # _____

Secondary Insurance Co. Name _____

Name of Insured _____ SS # _____ DOB _____

Policy # _____ Group # _____

Medicare # _____ Medicaid # _____

Primary Care Physician _____

Reason for visit _____

Is the problem an accident ☐ or illness ☐ Date of Accident _____

If accident was it work related? _____

Brief details of accident _____

I hereby assign, transfer, and set over to Augusta Orthopedic Specialists, PC. all of my rights, title, and interest to my medical reimbursement benefits under my insurance policy. I authorize the release of any medical information needed to determine these benefits. This authorization shall remain valid until written notice is given by my revoking said authorization. I understand that I am financially responsible for all charges whether or not they are covered by insurance.

Signature _____ Date _____