PATIENT INFORMATION **Child lives with: __Both parents __Mother __Father Other:________________________**

Last Name First Middle Today's Date

Street Address : Parent/Guardian Street City State Zip

Mailing Address : Parent/Guardian P.O. Box or Other City State Zip

Date of Birth Age Sex Social Security Number (Area code) Home Phone

PATIENT BROUGHT TO APPOINTMENT BY: ________________________

Name (please print) Relationship

Who referred you to our office? ________________________

Doctor's Name City (Area code) Phone

PARENT OR GUARDIAN INFORMATION:

Last Name First Middle Relationship to Patient

Date of Birth Social Security Number Marital Status (Area code) Home Phone

STREET ADDRESS:________________________

(Skip if same as child) Street City State Zip

Employer Name Number Street City State Zip

Department/Occupation How Long? (Area code) Work Phone Extension

PARENT OR GUARDIAN NOT LISTED ABOVE:

Last Name First Middle Relationship to Patient

Date of Birth Social Security Number Marital Status (Area code) Home Phone

STREET ADDRESS:________________________

(Skip if same as child) Street City State Zip

Employer Name Number Street City State Zip

Department/Occupation How Long? (Area code) Work Phone Extension

❑ **PRIMARY CARE DOCTOR:** ________________________

Name City (Area code) Phone

❑ **EMERGENCY CONTACT (MUST BE SOMEONE NOT LIVING WITH PATIENT)**

Last Name First Name Middle Relationship to Patient (Area code) Home Phone

Number Street City State Zip (Area code) Work Phone Extension

DATE:______________ **PATIENT**:____ **DOB:**________________

1. Please describe injury or problem for which you wish to be seen today.
   Important: Please specify "right" or "left" as in " numbness in left hand", etc.

   ____

   ____

   ____

2. Is condition/injury the result of an accident? ___Yes ___No

   If yes, date of accident______________________ or date of first symptom______________________
   Please specify type of accident: ___Work ___Automobile ___Home ___Place of Business
   ___School Other:__________________________________

3. Is there any insurance, liability coverage, or third party responsible for payment of treatment related to this accident/condition other than your own group health insurance? ___Yes ___No

   If yes, please explain:____

   ____

4. Have you been treated previously for this injury/problem? ___Yes ___No

   If yes, When?_____________________________________Where?_________________________________

   Doctor's name____ Were x-rays taken? ___Yes ___No

   Please describe treatment____

   ____

AUTHORIZATION FOR TREATMENT, ASSIGNMENT OF BENEFITS, AND RELEASE OF INFORMATION

I authorize Georgia Bone & Joint Surgeons, P.C./Center For Orthopedic Surgery and providers thereof to render treatment and to release any medical information(including information related to psychiatric care, drug/alcohol abuse, and HIV/AIDS) necessary to process claims, for any utilization review or quality assurance activities, or if and when applicable, as requested by subpoena, request for production of documents, or other court order, whether released verbally, written, or by fax. I assign all medical and/or surgical benefits including major medical benefits to which I am entitled for this or any other claim filed related to treatment received at Georgia Bone & Joint Surgeons, P.C./Center For Orthopedic Surgery. **This assignment and authorization shall remain in effect unless revoked by me in writing**. A photocopy of this authorization shall be considered as effective and valid as the original. **I understand that, even though I may have some type of insurance coverage, I am responsible for payment of services.** I further understand that **as the person authorizing treatment for a minor child, I am responsible for the charges incurred** regardless of other agreements in place. By signing below, I am affirming that I have completed this form fully and that the information furnished is correct to the best of my knowledge. I am also affirming that I have read and understand the contents of the authorization above and my responsibilities therein. If I am insured by Medicare, I authorize any holder of medical or other information about me to release to the Social Security Administration and Health Care Financing Administration or its intermediaries or carrier, any information needed for this or a related Medicare claim whether verbal, written, or by fax. I permit a copy of this authorization to be used in place of the original and request payment of medical insurance benefits to the party who accepts assignment. Regulations pertaining to Medicare assignment of benefits apply

METHOD OF PAYMENT TODAY: ____Check ____Cash ____Credit Card ____Money Order

X____ X____

Patient Signature **Date** **Person Giving Consent / Relationship to Patient Date**