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(706) 425-2400 Phone
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PATIENT INFORMATION

PATIENT INFORMATION

Date________________

Patient____
First Middle Initial Last
Address____
Street Address Required
____
City State Zip
Sex: ☐M ☐ F Age___________ Birthdate____________
☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced
Patient SS#____
Occupation____
Employer____
Employer Address____
____
Employer Phone____

SPOUSE ☐ *N/A*
Name____
Birthdate__________________ SSN______________
Occupation____
Employer____

OTHER PHYSICIANS
Referring Physician____
____
Primary Care Physician____
____

PHONE NUMBERS

Home ____
Work ____
Cell ____
Email ____

IN CASE OF EMERGENCY, CONTACT:
Name ____
Relationship____
Home ____
Work ____
Cell ____

OTHER CONTACT INFO:
(Someone with DIFFERENT phone number than yours)
Name ____
Relationship____
Home ____
Work ____
Cell ____

INSURANCE INFORMATION

Who is responsible for this account?________________
Relationship to Patient______________________________

PRIMARY INSURANCE ☐ *Copy ID card on file*
Company____
Subscriber____
Policy #____________________ Group #____________

SECONDARY INSURANCE ☐ *Copy ID card on file*
Company____
Subscriber____
Policy #____________________ Group #____________
Birthdate____________________ SSN______________
Relationship to Patient______________________________

ASSIGNMENT AND RELEASE
I, the undersigned certify that I (or my dependent) have current insurance coverage listed above and assign directly to Athens Spine Center all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize Athens Spine Center to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

____
Responsible Party Signature

____ Date____________
Relationship to Patient

ACCIDENT INFORMATION

Is condition due to an accident? ☐ No ☐ Yes
Date of Accident____
Type of Accident ☐ Auto ☐ Work ☐ Home ☐ Other

Report of accident made to
☐ Auto Insurance ☐ Employer ☐ Workers Comp ☐ Other

Auto Insurance Carrier______________________________
Workers Comp Carrier______________________________

Adjustor____
Claim #____

Attorney ____
____