



Patient Registration

Date: _____

NAME: Last: _____ First: _____ MI: _____ SSN: _____ - _____ - _____

Mailing Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____ Date of Birth: ____/____/____ Age: _____

Sex: Male Female Marital Status: Single Married Divorced Legally Separated Widowed

Dependent Status: N/A Dependent Child under 18 Full-time Student over 18 Part-time Student over 18

Your Occupation: _____ If retired, date you retired ____/____/____

Employer: _____ Address: _____ Work Phone: _____ EXT _____

Emergency Contact NOT living with you: _____ Phone: _____

Relationship: _____

If married:

Spouse's name: _____ Date of Birth: ____/____/____ SSN: _____ - _____ - _____

Spouse's Occupation: _____ Employer: _____ Work Phone: _____

Who is responsible (the guarantor) for this account? Self Father Mother Other legal guardian

Guarantor Information (If self, skip to next section)

NAME: _____ Relationship: _____ SSN: _____

Mailing Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Employer: _____ Work Phone: _____

A copy of your medical insurance card or State Medicaid card is required for billing. It is very important that all information be filled out completely and accurately, Insurance is considered a contract between the patient and the insurance company for reimbursement of certain medical fees. If you have medical insurance, we will bill the insurance company. However, it is your responsibility to pay deductibles, co-pays, or balances not paid by the insurance within a reasonable time.

PRIMARY MEDICAL INSURANCE - COMPANY NAME: _____

Insured: Self Spouse Other: _____ Insured Birth Date: ____/____/____ Policy #: _____

SECONDARY MEDICAL INSURANCE - COMPANY NAME: _____

Insured: Self Spouse Other: _____ Insured Birth Date: ____/____/____ Policy #: _____

DATE OF INJURY OR ONSET OF PROBLEM: _____

ACCIDENT RELATED: Y N WORK RELATED? Y N AUTO ACCIDENT? Y N (We will not file motor vehicle insurance)

How did injury occur: _____

Employer at time of injury (if Work Related): _____

How did you hear about Georgia Bone and Joint? (Please circle all that apply)

Primary Doctor ER Friend Website Another Patient Advertisement TV

Yellow Pages School Contact Hospital Other _____