Rehabilitation Physicians of Georgia, P.C.

Patient Information

Name: ______________________________
Last, First, MI

____
Street Address Apt No.

____
City, State, Zip Code

Home phone: ______________________________

Cell/Pager: ______________________________

Emergency Contact Name: ______________________________

Emergency Contact #: ______________________________

Employer: ______________________________

Work phone: ______________________________

Social Security #: ______________________________

Date of Birth: ____________________ Age: ________

Sex: M F Marital Status: S M D W

Spouse's Name: ______________________________

Referred By

Name: ______________________________

Phone: ______________________________

Fax: ______________________________

Insurance Information

If this is a Workers' Compensation claim, please skip Part A and complete Part B.

Part A

Primary Ins: ______________________________

Phone: ______________________________

Send claims to: ______________________________

____

Group #: ______________________________

Policy #: ______________________________

Policy Holder: ______________________________

Relationship: Self Spouse Mother Father

Secondary Ins: ______________________________

Phone: ______________________________

Send claims to: ______________________________

____

Group #: ______________________________

Policy #: ______________________________

Policy Holder: ______________________________

Relationship: Self Spouse Mother Father

Part B Workers' Compensation Automobile Accident (Please circle one)

Date of Accident: ______________________________

Adjuster: ______________________________

Phone No: ______________________________

Case Manager: ______________________________

Phone No: ______________________________

Send claims to: ______________________________

____

____

____

Claim #: ______________________________

Please read and sign: I consent to treatment by any medical professional associated with Rehabilitation Physicians of Georgia, PC. I authorize the release of any medical information needed by a physician's office, insurance company, attorney, or hospital. I authorize payment for medical benefits directly to the physician for his/her services. I understand that I am financially responsible for charges not covered by my insurance.

Signature: ______________________________ Date: ____________________
Patient / Parent / Guardian