Rehabilitation Physicians of Georgia, P.C.

Patient Information

Name:_____ Social Security #:_____

Address:_____ Date of Birth:_____ Age:_____

_____ Sex: M F Marital Status: S M D W

Race: ☐ American Indian ☐ Alaska Native ☐ Asian ☐ Black ☐ Hispanic ☐ Pacific Islander ☐ White ☐ Refused to Answer **Ethnicity**: ☐ Hispanic ☐ Non Hispanic ☐ Refused to Answer **Language**: _____

Home Phone:_____ Spouse's Name: _____

Cell/Pager:_____

Emergency Contact #:_____

Employer:_____

Work Phone:_____

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:_____ Secondary Ins: _____

Phone:_____ Phone: _____

Send claims to: _____ Send claims to: _____

_____ _____

Group #: _____ Group #: _____

Policy #: _____ Policy #:_____

Policy Holder: _____ Policy Holder: _____

Relationship: Self Spouse Mother Father Relationship: Self Spouse Mother Father

Part B

Workers' Compensation Automobile Accident (Please Circle One)

Date of Accident: _____ Send claims to:_____

Adjuster:_____ _____

Phone #: _____ _____

Case Manager: _____ _____

Phone #: _____ Claim #:_____

Please read and sign: I consent to treatment by any medical professional associated with Rehabilitation Physicians of Georgia, P.C. 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 physicians for his/her services. I understand that I am financially responsible for charges not covered by my insurance.

Signature: _____ Date: _____

Patient / Parent / Guardian