

Orthopaedic Associates of Augusta, P.A.

PLEASE PRINT

Date _____

Referred by _____

<i>FOR OFFICE USE ONLY</i>		
Medical Record # _____	NP _____	EP _____
Registrar _____	IME _____	2nd Opinion _____
<input type="checkbox"/> Dr. Hudson	<input type="checkbox"/> Dr. Parfenchuck	<input type="checkbox"/> Dr. Phillips
<input type="checkbox"/> Dr. Carter	<input type="checkbox"/> Dr. Meredith	<input type="checkbox"/> Dr. Rectenwald
<input type="checkbox"/> Dr. Fullerton	<input type="checkbox"/> Dr. O'Shea	<input type="checkbox"/> Dr. Arrington
<input type="checkbox"/> Dr. Herzwurm		

Patient's full name _____ Soc. Sec. # _____

Mailing address _____ City _____ St. _____ Zip _____

Home phone (____) _____ Work phone (____) _____ Mobile phone (____) _____

Date of birth _____ Age _____ Male Female Married Single Widowed Divorced Separated

Employer _____ Occupation _____

Employer's address _____ City _____ St. _____ Zip _____

Spouse or Parent's information (provide parent or guardian information if patient is a minor)

Name _____ Date of Birth _____ Soc. Sec. # _____

Employer _____ Occupation _____

Employer's address _____ City _____ St. _____ Zip _____

Employer's phone # _____

Primary complaint or injury (specify right or left if applicable): _____

Date of accident or onset of symptoms _____ Auto accident Work Comp Other _____

How and where did injury occur? _____

Primary Insurance

Name of Insurance _____ Name of Insured _____

Policy # _____ Insured's date of birth _____

Group # _____ Insured's Soc. Sec. # _____ Relationship to patient _____

Mail claim to: _____

Employer's name and address _____

Secondary Insurance

Name of Insurance _____ Name of Insured _____

Policy # _____ Insured's date of birth _____

Group # _____ Insured's Soc. Sec. # _____ Relationship to patient _____

Mail claim to: _____

Employer's name and address _____

Worker's Compensation Information

Mail claim to: _____

Verified by: _____ Phone # (____) _____

I consent to treatment and I authorize Orthopaedic Associates of Augusta, P.A., to release to any insurance company or government agency any and all information necessary to process this claim. I request that payment be made either to me or to the party who accepts assignment of this claim. I understand that charges not covered by my insurance carrier are my responsibility. I permit a copy of this authorization to be used in place of the original.

Signature _____ Date _____