

# Georgia Orthopedic Resources Patient Registration Form

Patient Information Check box  if information has changed since last visit

Patient Name \_\_\_\_\_ Patient's DOB \_\_\_\_/\_\_\_\_/\_\_\_\_  
First Middle Last

Home Address \_\_\_\_\_

Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_  
Street Height Weight

E mail \_\_\_\_\_  Male  Female

Is the Patient Diabetic?  Yes  No Diabetic Doctor \_\_\_\_\_ Dr. Phone \_\_\_\_\_

SSN# \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Referring Doctor \_\_\_\_\_ Dr. Phone \_\_\_\_\_

Have you ever been treated by a Physical or Occupational Therapist?  Yes  No If yes, who? \_\_\_\_\_

Appointment Location \_\_\_\_\_ Accident Date \_\_\_\_/\_\_\_\_/\_\_\_\_

Have you ever worn an orthotic device (brace) before?  Yes  No If yes, what kind? \_\_\_\_\_

Primary Insurance \_\_\_\_\_ ID # \_\_\_\_\_

Policy Holder's Name \_\_\_\_\_ DOB \_\_\_\_/\_\_\_\_/\_\_\_\_

Secondary Insurance \_\_\_\_\_ ID # \_\_\_\_\_

Secondary Policy Holder's Name \_\_\_\_\_ DOB \_\_\_\_/\_\_\_\_/\_\_\_\_

Name of the school the child attends \_\_\_\_\_ Phone number \_\_\_\_\_

Surgeries \_\_\_\_\_ Allergies \_\_\_\_\_

Medications \_\_\_\_\_

## For minor Patients please provide information about the person responsible for payment

Name \_\_\_\_\_ Work Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

Address \_\_\_\_\_ SSN# \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Relationship to Child \_\_\_\_\_ Email address \_\_\_\_\_

\*\*\*\*\*

I grant to Georgia Orthopedic Resources the rights to use pictures of \_\_\_\_\_ for marketing and training purposes.

**Name of Patient**

Signature: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

By signing below, I authorize the release of any medical or other information to process the claim for services rendered by South GA Orthopedic Resources. I also request payment of benefits to South GA Orthopedic Resources for these Services. South GA Orthopedic Resources will attempt to verify insurance benefits before you leave the office. If we are unable to verify your insurance, we will attempt to bill your insurance. However, you understand that you will be responsible for any balance due to South GA Orthopedic Resources as a result of no coverage, partial payment, deductible or co-payment. We expect payment at the time services are rendered or a payment plan to be arranged.

Signature \_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_

I certify that I was offered a copy of South GA Orthopedic Resources Notice of Privacy Practices. The Notice of Privacy Practices describes the types of uses and disclosure of my protected health information that might occur during my treatment, payment of my bills, or in the performance of South GA Orthopedic Resources health care operations. By signing this form, I consent to use or disclosure of my protected health information by South GA Orthopedic Resources for the purpose of providing treatment to me, obtaining payment for my healthcare bills or to conduct South GA Orthopedic Resources healthcare operations.

X \_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_

Signature of Patient or Personal Representative Name of Patient or Personal Representative