



PATIENT REGISTRATION

What location are you being seen at: South Hall, Cumming, Duluth
(Please circle one)

How did you hear about us?

- Internet: [] Google [] Yahoo [] Yellow Pages.com
[] Friend/ Family [] Insurance Co. [] I am a previous patient [] Other
[] Doctor:

PATIENT INFORMATION

- [] New Patient [] New Problem [] Updating Info.

Form with fields for: First Name, Middle Initial, Last Name, Social Security #, Date of Birth, Age, Sex, Home Phone, Cell Phone, Work Phone, Home Address, City, State, Zip Code, Marital Status, Employer, Email Address, Employed status, Occupation, Emergency contact, Pharmacy Name, Location, Pharmacy phone #.

Do you have medical insurance coverage that you will be using for your doctor visits and treatment? Yes No

Academy Orthopedics, LLC will file your primary and secondary insurance as a courtesy to you. Please make sure to fill out both sections of the insurance information if you have primary and secondary insurance and you wish us to file both on your behalf. PLEASE NOTE WE DO NOT FILE AUTO OR HEALTH INSURANCE IF THIS VISIT IS DUE TO AN AUTO ACCIDENT.

Primary Insurance Plan

Who is the primary person on the insurance plan? It is my plan My husband's/wife's plan Someone Else

Primary Insured's Information:

Last Name:	First Name:	Middle Initial:
Social Security #: --- ---	Date of Birth: / /	Age: /
		Sex: Male <input type="checkbox"/> Female <input type="checkbox"/>
Insured's Employer:		

INSURANCE DETAILS:

My plan is: PPO POS HMO Medicare Medicaid/Peachcare Other: _____

Insurance Company: _____ My Specialist Co-pay is \$ _____

Member ID# _____ Group ID # _____

Secondary Insurance Plan

Who is the primary person on the insurance plan? It is my plan My husband's/wife's plan Someone Else

Primary Insured's Information:

Last Name:	First Name:	Middle Initial:
Social Security #: --- ---	Date of Birth: / /	Age: /
		Sex: Male <input type="checkbox"/> Female <input type="checkbox"/>
Insured's Employer:		

INSURANCE DETAILS:

My plan is a PPO POS HMO Medicare Medicaid/Peachcare Other: _____

Insurance Company: _____ My Specialist Co-pay is \$ _____

Member ID# _____ Group ID # _____

I understand that I will be responsible for all charges incurred by me. Should collection proceedings become necessary, I agree to pay all costs of collection, including reasonable attorney's fees. I hereby assign to and authorize payment directly to the treating physician all benefits payable under the terms of any insurance policy. I realize the insurance benefits may not pay the entire bill(s) and I agree to pay the difference or the entire bill if necessary. I authorize the release of any medical information necessary to process claims on any insurance policy listed above or provided separately

Patient/Guardian Signature: _____ Date: _____

HEALTH CLAIM ACCIDENT AND AILMENT QUESTIONNAIRE

Please note that this form is used to determine insurance coverage eligibility and is forwarded to your insurance plan as appropriate.

Patient Name: _____ DOB: _____

Did you have an accident or an injury of any kind? No Yes, Date of accident or injury: _____

If you did not have an accident/injury, describe when you first started having this problem/pain: _____

If it was an accident or injury, did it happen on the job? No Yes

Was this due to an auto accident? No Yes Date of auto accident: _____

PLEASE NOTE WE DO NOT FILE AUTO OR HEALTH INSURANCE IF THIS VISIT IS DUE TO AN AUTO ACCIDENT.

Have you hired an attorney in relation to your current health problem? No Yes

Attorney Name: _____ Phone Number: _____

Accident Details:

What happened? _____

When did it occur? _____ Where? _____

Have you ever seen anyone for this problem in the past? No Yes When? _____

Is there anything else we should know about your condition or situation? _____

To the best of my knowledge, I attest the information provided above is true and accurate.

Patient/Guardian Signature: _____ Date: _____

