Atlanta Pain Doctors

770-447-5971
3030 Holcomb Bridge Road, Suite F
Norcross, Georgia, USA 30071

Patient Registration Form

First	Middle		Last	Sex ❑ Male ❑ Female	
Address			City	State	Zip
Home phone	Work phone		Cell phone	SS #	
Birth date	Age	Race	Marital status	Spouse's name	
Patient's employer			Patient's occupation		
Employer's address			City	State	Zip

Responsible Party (if other than patient)

First	Middle	Last	Sex ❑ Male ❑ Female	
Address		City	State	Zip
Home phone	Work phone	Cell phone	SS #	
Responsible party's employer		Occupation	How long employed	
Employer's address		City	State	Zip

Insurance Information

Primary insurance company		Phone		
Address		City	State	Zip
Insured's name	Insurance ID #	Group #	Birth date	
Secondary insurance company		Phone		
Address		City	State	Zip
Insured's name	Insurance ID #	Group #	Birth date	

Other Information

Is this visit a result of a work injury? ❑ Yes ❑ No	Date injured	Industrial claim #
Is this visit a result of a car accident? ❑ Yes ❑ No	Date injured	Attorney name
Is the patient a full-time student? ❑ Yes ❑ No	School name	
Who can we thank for referring you to us?		

I, the undersigned, hereby acknowledge that it is the policy of this office that all payment be made at each visit and that I am responsible for payment of all services for the above patient to the above physician not covered by workman's compensation or other benefits agreed by the provider of such services. I authorize the release of any medical information necessary to process the claim to third party carriers and also certify that the information contained herein is correct. I authorize payment of medical benefits to the physician or supplier for services rendered.

Signature of patient, parent or guardian if patient is a minor   Date