

PATIENT INFORMATION RECORD

Name _____ SS # _____ PHONE (AC _____) _____

Address (Street) _____ (City) _____ (State) _____ Zip Code _____

MARITAL STATUS: S - M - W - D - SEP		DATE OF BIRTH:	AGE:	SEX:	RACE:
SPOUSE'S NAME:			PARENT / GUARDIAN NAME:		
ALLERGIES:			EMERGENCY CONTACT - (Not Living With You) NAME AND PHONE NO.:		
EMPLOYMENT INFORMATION					
PATIENT		EMPLOYER NAME:			
EMPLOYER ADDRESS:			BUSINESS PHONE:	MOBILE PHONE:	
GUARANTOR		IF OTHER THAN PATIENT	GUARANTOR NAME:		RELATIONSHIP TO PATIENT:
SS#		EMPLOYER NAME			
EMPLOYER ADDRESS:			BUSINESS PHONE:		
MEDICAL INFORMATION					
CHIEF COMPLAINT:					IS THIS THE RESULT OF AN INJURY? <input type="checkbox"/> Yes <input type="checkbox"/> No
DATE OF INJURY:		TYPE OF INJURY: <input type="checkbox"/> AUTO <input type="checkbox"/> WORK <input type="checkbox"/> SPORT <input type="checkbox"/> OTHER			
HOW DID YOU HURT YOURSELF?			IF NOT AN INJURY, BUT AN ILLNESS, HOW LONG HAS PROBLEM BEEN GOING ON?		
HAVE YOU BEEN TREATED BY ANOTHER DOCTOR FOR THIS PROBLEM?			IF SO, PLEASE GIVE OTHER DOCTOR'S NAME, ADDRESS AND PHONE NO.:		
DID YOU GO TO AN EMERGENCY ROOM FOR THIS PROBLEM?		IF SO, WHICH ONE?		WHEN?	
WERE X-RAYS TAKEN? <input type="checkbox"/> Yes <input type="checkbox"/> No		ARE YOU SEEKING A SECOND OPINION? <input type="checkbox"/> Yes <input type="checkbox"/> No		FOR X-RAY PURPOSES, ARE YOU PREGNANT? <input type="checkbox"/> Yes <input type="checkbox"/> No	
WERE YOU REFERRED TO OUR OFFICE FOR THIS PROBLEM?		IF YES, BY WHOM? <input type="checkbox"/> ANOTHER DOCTOR <input type="checkbox"/> PATIENT <input type="checkbox"/> FRIEND		YELLOW PAGES <input type="checkbox"/> NEWSPAPER <input type="checkbox"/> FAMILY MEMBER <input type="checkbox"/> OTHER	
IF BY ANOTHER DOCTOR, PLEASE LIST DOCTOR'S FULL NAME, ADDRESS AND PHONE NUMBER:					
INSURANCE INFORMATION					
#1		NAME OF INSURANCE COMPANY:			
POLICY NUMBER:		GROUP NUMBER:		EFFECTIVE DATE OF POLICY:	
INSURED'S NAME:		INSURED'S SS#:		INSURED'S BIRTHDATE:	
PATIENT'S RELATIONSHIP TO INSURED:					
#2		NAME OF INSURANCE COMPANY:			
POLICY NUMBER:		GROUP NUMBER:		EFFECTIVE DATE OF POLICY:	
INSURED'S NAME:		INSURED'S SS#:		INSURED'S BIRTHDATE:	
PATIENT'S RELATIONSHIP TO INSURED:					
WORKER'S COMPENSATION INFORMATION					
DATE OF INJURY		EMPLOYER NAME		EMPLOYER PHONE	
EMPLOYER ADDRESS - STREET & NO.		CITY	STATE	ZIP CODE	CONTACT PERSON

CONSENT FOR TREATMENT

I authorize The Hughston Clinic, P.C. to perform treatment deemed by the physician in exercise of professional judgement to be of appropriate kind and method on me / my dependent. I hereby authorize The Hughston Clinic, P.C. to release any information acquired in my examination or treatment to any insurer, government agency providing benefits, or to anyone for charges.

X SIGNED _____ DATE _____

INSURANCE ASSIGNMENT

I hereby assign to and authorize payment to The Hughston Clinic, P.C. of all benefits payable under the terms of any insurance policy listed above. I realize the insurance, workmen's compensation, and / or liability claims may not pay all of the bill. I agree to pay the difference or the entire bill if necessary. I also agree to pay costs of collection, including attorney's fee and waive my exemption under the constitution and laws of the states of Georgia and Alabama.

X SIGNED _____ DATE _____

CONSENT TO TREAT WITH ASSOCIATE PHYSICIAN AND/OR PHYSICIAN ASSISTANT

By my signature below I acknowledge that I have been informed that The Hughston Clinic, P.C. and/or my Physician may utilize an Associate Physician and/or a Physician Assistant for medical services rendered. I have further been informed that as a courtesy, my insurance will be billed for these services and any balance will be my responsibility.

X SIGNED _____ DATE _____