4898 Austell RD
Austell GA 30068

Phone: 770-635-8407
Fax: 770-635-8017

**Today's Date: _____/ _____/ _____**

# PATIENT INFORMATION SHEET

First: _____ M.I.: _____ Last Name: _____

Street: _____ Apt: _____ City: _____ State: _____ Zip: _____

Home Phone: (_____) _____-_____ Work Phone: (_____) _____-_____ Cell Phone (_____) _____-_____

DOB: _____/_____/_____ SSN: _____-_____-_____ Email: _____

Main reason for visit: _____

Male ☐ Female ☐

Worker's Compensation Claim Y ☐ N ☐

Private Physician: _____ Physician's Phone: (_____) _____-_____

Emergency Contact Name: _____ Phone: (_____) _____-_____

Responsible Party for Bill _____ Relationship: _____

**Primary Insurance Information** **None** ☐ **Same as information listed above** ☐

**Name of Insurance Company** _____

Policy Holder: _____ Relationship: _____

DOB: _____/_____/_____ Name & Phone of Employer: _____

ID # _____ Group #_____ Effective Date: _____/_____/_____

**Secondary Insurance Information** **None** ☐ **Name**_____

Policy Holder: _____ Relationship: _____

DOB: _____/_____/_____ Name & Phone of Employer: _____

Policy # _____ Group #_____

I give UCPT and or its representative permission to file my claims with my insurance carrier. Also, I understand that after insurance claim as been adjudicated and adjustments for assigned fee schedules have been made, any remaining balance will be due within thirty (30) days of notification. Notification will be provided by UCPT in the form of a patient statement mailed to the address provided above. After the thirty-day period I understand my account may be turned over for collections and that all fees related to this collection are my responsibility

**Patient Signature**: _____

Patient Representative (print): _____ Relationship: _____

Representative's Signature: _____ **Today's Date**: _____/ _____/ _____

Please bring this form back with your driver's license and insurance card. Please sign the second page.