

4898 Austell RD Austell GA 30068

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

Today's Date: ____/ ____/ _____

PATIENT INFORMATION SHEET

Main reason for visit: Male Female Worker's Compensation Claim Y N Private Physician's Phone: (First:	M.I.: _		Last Name:			
Main reason for visit: Male Female Worker's Compensation Claim Worker's Compensation Claim Private Physician: Emergency Contact Name: Emergency Contact Name: Phone: Phone: Phone: Phone: Primary Insurance Information None Same as information listed above Name of Insurance Company Policy Holder: DOB: Name & Phone of Employer: ID # Group # Group # Effective Date: Policy Holder: DOB: Name & Phone of Employer: Belationship: Belationship: DOB: Name Policy Holder: Group # Group # 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 mailec to the address provided above. After the thirty-day period I understand my account may be turned over for collections and tha all fees related to this collection are my responsibility Patient Signature:	Street:	Apt:	City: _		State:		_ Zip:
Main reason for visit: Male	Home Phone: ()	Work Phone: (_)		Cell Phone ()_	-
Male Female Worker's Compensation Claim Y N Physician's Phone: ()	DOB:/ SSN: _			Email:			
Male Female Worker's Compensation Claim Y N Physician's Phone: ()	Main reason for visit:						
Private Physician: Physician's Phone: (
Emergency Contact Name:	Worker's Compensation Claim	Y N					
Responsible Party for Bill	Private Physician:			Phys	ician's Phone: ()_	-
Primary Insurance Information None Same as information listed above Name of Insurance Company Policy Holder:	Emergency Contact Name:				Phone: ()_	
Name of Insurance Company Policy Holder:	Responsible Party for Bill				Relationship:		
Policy Holder:	Primary Insurance Information	None	Same	as informatio	n listed above		
DOB:/Name & Phone of Employer:	Name of Insurance Company						
Secondary Insurance Information None Name Policy Holder:	Policy Holder:	Rela	ationship	:			
Policy Holder:	DOB:/Name & P	hone of Employe	er:				
Policy Holder:	ID#	Group #	<u> </u>		Effective Date:		
Policy # Group # _	Secondary Insurance Information	None	Name_				
Policy # Group # Group # 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 tha all fees related to this collection are my responsibility Patient Signature:	Policy Holder:	Rela	ationship	:			
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					lationship		
• • • •	Representative's Signature:			Ke	• ——		

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