www.precisioninjurycare.com

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Phone: 678-666-4088 Fax: 678-666-4033

Name____Age______Date______________________________

Address ___________________________________City ___________State _____ Zip _______________________

Male / Female Date of Birth _________________ SS#_________________________ Email__________________

Home Phone _____________________Cell Phone____________________ Work Phone_______________________

Primary Care Doctor____

Referring Physician_______________________________Phone____

Employer____ Occupation ________________________________

Business Address___________________________ City________________________State_____ Zip ___________

Health Insurance Company________________________ID#_______________Group#________________________

Spouse_______________________________ Spouse's Employer _______________________________________

Emergency Contact______________________Relationship______________ Phone________________________

Is your problem today the result of Workers Comp _______Yes ___________No ______________________________
If yes, what is the name of the case worker? _________________ _Name of Workers Comp Co._________________
Phone___________________ Claim No______________________ Date of Injury_____________________________

Is your problem today from the result of Auto Accident _______Yes _________No _____Date of Accident ________
Name of Automobile Insurance Carrier____________________ Phone No.__________________________________
Adjustor Name________________________________ Claim No.____
Medpay Limit $___________________________ How much has been used? _________________________________

Attorney name and Phone number____

I authorize the release of any medical information necessary to process my insurance claim. I hereby authorize payment to be made to Precision Healthcare, PC. I understand any unpaid balance is my financial obligation. As a courtesy we bill your insurance directly, however the insurance and or settlement checks may be sent to you, made out in your name. I agree to bring these checks to Precision Healthcare, P.C. I agree not to tear apart the check from the explanation of benefits. If I fail to bring payments received from my insurance company or settlement within three business days of receipt, I will be responsible for the entire amount billed.

____________________________ ____________________________
Patients Signature Date Witness Signature Date