

EAST COBB FOOT & ANKLE CARE

4439 Roswell Road, Marietta, GA 30062 770-977-8221, 770-977-8222 fax
670 Canton Road, Marietta, GA 30060 770-429-0033, 770-429-0360 fax
www.eastcobbfoot.com

Patient Registration

Last Name _____ SS#: _____

First Name: _____ Middle: _____ sex: Female
Male

Address: _____
City: _____ Marital Status: Divorced, Legally Separated
Married, Single, Widowed

State: _____ Zip: _____ Primary Care Physician: _____ Phone: _____

Primary Care Physician Address: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____ Ext: _____

Birth date: _____ Employer: _____

Occupation: _____ Employer Address: _____

Is this your first visit with our doctor? _____
If not, when and where did he see you? _____

Name: _____ Address: _____ phone: _____ of nearest relative **NOT** living with you

Primary Insurance Co. Name: _____ Patient's relationship to Primary Insurance
I.D. or Subscriber #: _____ Policyholder: _____
Policyholder's name and date of birth: _____

Secondary Insurance Co. Name _____ Patient's relationship to Secondary Insurance
I.D. or Subscriber #: _____ Policyholder: _____
Policyholder's name and date of birth: _____

Are you seeking treatment for a work related injury? _____
(If yes, explain nature of injury)

Referred by: Primary Care Physician: _____ Insurance referral or authorization #: _____
Other Doctor: _____
Insurance: _____ Number of visits: _____ expires: _____
Family member _____
Internet _____ Date of last visit with
Yellow pages: _____ Primary Care Physician: _____
Other source: _____

E-mail address: _____ How do you wish to be contacted by us? _____

I understand that I am ultimately responsible for the balance on my account for services rendered. I authorize payment of any medical benefits directly to East Cobb Foot & Ankle Care for services rendered. I authorize the release of any medical information necessary to process any insurance claim.

Patient or Authorized person's signature: _____ Date: _____