Georgia Foothills Hand Surgery
980 East Main Street, Suite 300
Blue Ridge, GA 30513
Tel: 706-946-7300 Fax: 706-946-7305 Cell: 678-628-8565
Web: www.georgiafoothillshandsurgery.com

PATIENT INFORMATION Today's Date: ___/___/___

Legal Name: ____
Last Name First Name Middle Name

Marital Status: _____ Date of Birth: ___/___/___ Gender: M F Social Security # ______________

Street Address (required): ______________________________ P.O. Box ________

City: __________________________ State: ________ Zip Code: ______________

Cell Phone: ____________________ Alternate Phone: ______________________

Emergency Contact: ____
Name Phone Number Relationship

Employer: ____________________ Occupation: ______________________

E-mail: ______________________ Language: □ English □ Spanish

Ethnicity: □ Not Hispanic/Latino □ Hispanic/Latino

Race: □ American Indian/Alaska Native □ Asian □ Black/African American

□ Native Hawaiian/Other Pacific Island Native □ White/Caucasian

Pharmacy Name: ____________________ Phone Number: ______________________

Pharmacy Address: ____

INSURANCE INFORMATION

Person Responsible for Bill: ______________________ Birthdate: ___/___/___

Address (If different): ____

Phone Number: __________________ Social Security Number: ______________________

Your relationship to responsible person: ________________ Referral Needed? Y N

Responsible Person's Employer: ____________________ Employer Phone: ______________

Insurance Company: __________________________ Phone Number: ______________

ID Number: __________________________ Group Number: ______________

Secondary Insurance Company: ____________________ Phone Number: ______________

ID Number: __________________________ Group Number: ______________

The above information is true to the best of my knowledge. I authorize my insurance benefits to be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Dean D. Worthingstun, D.O. or the insurance company to release any information required to process my claims.

Patient/Guardian Signature: ________________________ Date: ____________

Revised 12/03/14