SPINE AND ORTHOPEDICS OF ATLANTA, LLC DAMIEN DOUTE' MD

PATIENT REGISTRATION

TODAYS DATE / /

PATIENT INFORMATION

LAST NAME	FIRST	MI	ADDRESS	EMAIL ADDRESS

CITY	STATE	ZIP CODE	SEX	AGE	HOME PHONE	CELL PHONE	WORK PHONE

DATE OF BIRTH	EMPLOYER/SCHOOL	MARITAL STATUS	RACE

EMPLOYED ☐ YES ☐NO	EMPLOYED ADDRESS	SOCIAL SECURITY #	DRIVERS LICENSE #

RESPONSIBLE PARTY STATEMENT – As the responsible party, I agree to pay all charges not paid by insurance.

LAST NAME	FIRST NAME	MI

ADDRESS	CITY	STATE	ZIP CODE

HOME PHONE	WORK PHONE	CELL OR MOBILE	RELATIONSHIP

PRIMARY CARE PHYSICIAN OR GROUP NAME

LAST NAME	FIRST NAME	ADDRESS	TELEPHONE

REFERRING DOCTOR OR PARTY OR GROUP NAME

LAST NAME	FIRST NAME	ADDRESS	TELEPHONE

DO YOU HAVE A REFERRAL # FOR YOUR VISIT TODAY?	WHICH HOSPITAL DO YOU USUSALLY GO TO?

IN CASE OF EMERGENCY, CALL:

NAME	WORK PHONE	HOME PHONE	CELL OR MOBILE

PRIMARY INSURANCE COMPANY INFORMATION

PRIMARY INSURANCE COMPANY NAME	IDENTIFICATION NUMBER	GROUP NUMBER

ADDRESS	CITY	STATE	ZIP CODE	PHONE

SUBSCRIBER (If other than patient)	SEX	DATE OF BIRTH

SOCIAL SECURITY NUMBER	PHONE NUMBER	RELATIONSHIP TO PATIENT

SECONDARY INSURANCE COMPANY INFORMATION

SECONDARY INSURANCE COMPANY NAME	IDENTIFICATION NUMBER	GROUP NUMBER

ADDRESS	CITY	STATE	ZIP CODE	PHONE

SUBSCRIBER (if other than subscriber)	SEX	DATE OF BIRTH

SOCIAL SECURITY NUMBER	PHONE NUMBER	RELATIONSHIP TO PATIENT

SIGNATURE _____