GEORGIA BLUE
FOOT AND ANKLE

INSURANCE POLICY

please print

FOR OFFICE USE ONLY:

PATIENT ID: _____

PRIMARY INSURANCE

Please provide us with your insurance card.

Subscriber's Name: _____ DOB: _____

Relationship to Patient: _____ SSN: _____

Insurance Company: _____ I.D. #: _____

Group #: _____

SECONDARY INSURANCE

Is patient covered by a *secondary insurance?*

Subscriber's Name: _____ DOB: _____

Relationship to Patient: _____ SSN: _____

Insurance Company: _____ I.D. #: _____

Group #: _____

- IF COPIES OF INSURANCE CARDS ARE NOT ATTACHED, PLEASE COMPLETE PATIENT INSURANCE FORM
- FAX COMPLETED FORM AND INSURANCE CARDS TO REGISTRATION SERVICES AT **770.280.3989**

☐ The information provided here is true to the best of my knowledge. I authorize release of any previous medical records by fax, mail or phone by either physician or hospital. I also hereby, authorize the doctor or assistant(s) to initiate the diagnosis and treatment of my condition with x-ray, examination or photographs of infections as necessary.

Patient Signature: _____ **Date:** _____

Print Name Here: _____

I HAVE PERSONALLY REVIEWED THE ABOVE INFORMATION

Patient Signature: _____ **Date:** _____

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