atlanta area Orthopedics
Andrew Harakas, MD

PATIENT INFORMATION SHEET

Patient Name: _____ _____ SS#_____
Last First MI

Mailing Address_____ Email _____

City/State_____ Zip_____

Home Phone #_____ Alternate Phone #_____

Physical Address _____

City/State_____ Zip_____

Date of Birth_____ Male_____ Female_____ Minor_____ Single_____ Married_____

Policy Holder's Name: _____SS#_____

Address_____ Phone #_____

Relationship to patient: Self_____ Parent_____ Spouse_____ Guardian_____ Date of Birth_____

Employed by _____ Occupation_____

Business Address_____ Phone #_____

City/State_____ Zip_____

Pharmacy Name _____ Location _____ Phone # _____

Hospital Preference (Please confirm that your insurance is in network.) _____

Lab Preference (Please confirm that your insurance is in network.) _____

In Case of an EMERGENCY whom should we contact?

Name _____ Relationship _____ Phone #_____

Referring Physician _____ **Primary Care Physician**_____

I authorize payment directly to the physician of benefits due for services rendered. I understand that I am financially responsible for charges not covered by the agreement. I authorize the physician and supplier to release any information required to process my insurance claims. I understand that if I am self-pay, payment is expected at time services are rendered. I understand that delinquent accounts are turned over to a collection agency and I acknowledge responsibility. I give this practice permission to electronically verify my insurance and prescription benefits, download my Rx history and communicate with me via email.

_____ _____
Patient Signature **Date** **Guarantor Signature** **Date**

LAWRENCEVILLE
725 Walther Road, Bldg. 200, Suite B
Lawrenceville, GA 30046

770-277-9222 ▪ AtlantaAreaOrtho.com