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Gary M. Lourie, M.D.
Allan E. Peljovich, M.D., M.P.H.
Jeffrey A. Klugman, M.D.
Joshua A. Ratner, M.D.



The Hand & Upper Extremity
CENTER OF GEORGIA, P.C.
SURGERY OF THE HAND, ELBOW AND SHOULDER

Northside Hospital Doctors Centre
980 Johnson Ferry Road NE, Suite 1020
Atlanta, Georgia 30342

Northside/Alpharetta Medical Campus
3400A Old Milton Parkway, Suite 350
Alpharetta, Georgia 30005

Hand & Upper Extremity Surgery Center
993D Johnson Ferry Road NE, Suite 200
Atlanta, Georgia 30342

(404) 255-0226 • www.HandCenterGA.com

Patient and Insurance Information

Today's Date: _____ Advance Directive: Yes No

PATIENT INFORMATION *(Please Print)*

First Name: _____ M.I. _____ Last Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____

Mobile Phone: _____ Date of Birth: _____ Age: _____

Social Security #: _____ Sex: Male Female

Email Address: _____

Employment Status: Employed Unemployed Retired

Employer: _____ Occupation: _____

Employer Address: _____

City: _____ State: _____ Zip: _____

Marital Status: Single Married Divorced Widowed

Spouse's Name: _____ Mobile Phone: _____

Spouse's Employer: _____ Work Phone: _____

If patient is a child, parent/guardian info :

Parent/Guardian #1: _____ Relationship to Patient: _____

Email: _____ Phone: _____ Mobile Phone: _____

Parent/Guardian #2: _____ Relationship to Patient: _____

Email: _____ Phone: _____ Mobile Phone: _____

Type of injury you are being treated for: Work Related Auto Accident Sports Injury
 Other

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Patient Name: _____

Date: _____

INSURANCE INFORMATION

(Please Print)

Primary Insurance Company:

Phone: _____

Policy #:

Group #:

Policy Holder Name:

Date of Birth:

Relationship to Patient:

Social Security #:

Secondary Insurance Company:

Phone: _____

Policy #:

Group #:

Policy Holder Name:

Date of Birth:

Relationship to Patient:

Social Security #:

Referring Physician: _____

Phone: _____

Emergency Contact (not in same household): _____

Relationship to Patient:

Phone: _____

Address: _____

City: _____

State: _____

Zip: _____

I do hereby consent to any medical care which is deemed advisable or necessary by my physician and grant authority to *The Hand and Upper Extremity Center of Georgia, P.C.*, to administer and perform all examinations, treatments, diagnostic procedures and surgeries needed now or in the future. I guarantee payment for all services rendered. All medical benefits including major medical benefits, private insurance and any other health plan, are assigned to The Hand and Upper Extremity Center of Georgia, P.C. The signature below confirms all of the information provided herein is true and accurate. Photocopy of this consent is to be considered as valid as the original.

Signature of Patient or Guardian _____

Date _____