SUTTON
ORTHOPAEDICS & SPORTS MEDICINE, P.C.

(770) 389-8386 Fax (770) 507-9576

Patient's Full Name: _____ Age: _____
Birthdate: _____ Sex: _____ Marital Status: _____
SS # : _____ Home Phone: ( ) _____ Cell Phone: ( ) _____
Street Address: _____ Apt / Lot # : _____
City: _____ State: _____ Zip Code: _____

Employer: _____ Postion: _____
Employer's Street Address: _____ Work # : ( ) _____
City: _____ State: _____ Zip Code: _____
Spouse Name: _____ SS # : _____
Spouse Birthdate: _____ / _____ / _____ Employer: _____
Position or Dept: _____ Work # : ( ) _____

If patient is a minor:

Father's Name: _____ DOB _____ SS # : _____
Fathers Employer _____ Work # : ( ) _____
Mother's Name: _____ DOB _____ SS # : _____
Mother's Employer _____ Work # : ( ) _____

Person to contact in Case of Emergency, (not living with you):
Name: _____ Relationship _____
Home # : ( ) _____ Work # : ( ) _____ Address: _____

Who referred you to us? _____ Family Dr. _____

Primary Insurance _____
Policy Holder ❒ Self ❒ Spouse ❒ Mother ❒ Father ❒ Other
Effective date of coverage _____
Secondary Insurance _____
Policy Holder ❒ Self ❒ Spouse ❒ Mother ❒ Father ❒ Other
Effective date of coverage _____

Patient Email: _____

I hereby authorize Sutton Orthopaedics & Sports Medicine, P.C. to release any medical information necessary to process a claim for services rendered. I further authorize assignment of benefits directly to physician. I understand that I am responsible for payment of services not covered by Insurance. A photostatic copy of this authorization shall be considered as effective and valid as the original.

Patient or Authorized Person (Signature) _____ Date _____

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