

# Winder Internal Medicine and Geriatrics Center P.C.

20 Satellite Dr. Ste 100, Winder, GA 30680

Phone (770) 586-0300, Fax (770) 586-0312

## Patient Registration Form for Third Party Liability

Date: \_\_\_\_\_ [ ] new [ ] update

### Patient Information

\_\_\_\_\_  
First Name MI Last Name

\_\_\_\_\_  
Mailing Address Birth Date Home Phone

\_\_\_\_\_  
City State Zip Cell Phone

\_\_\_\_\_  
Emergency Contact Phone Number

### Insurance Information

#### Insurance #1

Plan: \_\_\_\_\_ Subscriber ID: \_\_\_\_\_

Subscriber: \_\_\_\_\_ Relationship: self spouse child other

Subscriber DOB: \_\_\_\_\_ Effective Date: \_\_\_\_\_

#### Insurance #2

Plan: \_\_\_\_\_ Subscriber ID: \_\_\_\_\_

Subscriber: \_\_\_\_\_ Relationship: self spouse child other

Subscriber DOB: \_\_\_\_\_ Effective Date: \_\_\_\_\_

### Referral Information

Referring Doctor: \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_

### Third Party Liability

**MVA:** State where accident took place: \_\_\_\_\_

Date of Injury: \_\_\_\_\_

PIP Carrier Name: \_\_\_\_\_

Mailing Address: \_\_\_\_\_

City State Zip \_\_\_\_\_

Claim Number: \_\_\_\_\_

**Other Liability:** Work Comp [ ] Other [ ]

Date of Injury: \_\_\_\_\_

Carrier Name: \_\_\_\_\_

Mailing Address: \_\_\_\_\_

City State Zip: \_\_\_\_\_

Claim Number: \_\_\_\_\_