Stephanie S. Martin, M.D. • Shomari A. Ruffin, M.D.

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PLEASE NOTE THAT ALL ITEMS MARKED WITH * ARE REQUIRED

*** Patient's Full Name:**_____

***Full Address:** _____

***Home Number:** _____ **Mobile:**_____

***Social Security Number:** _____ ***Patient's E-mail:**_____

***DOB:** _____ **Marital Status:** ☐Single ☐Married ☐Divorced ☐Widowed ***Gender:** ☐F ☐M

Employer: _____ **Employer Phone Number:**_____

***Person Name Scheduling Appt.:** _____ **Referred By:** _____

If Patient is Minor:

Parent Name:**_____ *** DOB:** _____Social Security Number:** _____

***Type of Case**: ☐WC ☐MVA ☐Liability ***Appt Type**: ☐Attorney Lien ☐IME ☐WC NP ☐Medpay ☐Health Ins. ☐Funding Company: Name: _____

***Injured Body Part Sides:** ☐**Right** ☐**Left** ☐**Bilateral** ***Injured Body Part:** ☐**Back** ☐**Shoulder** ☐**Knee** ☐ **Hip** ☐**Ankle** ☐**Foot** ☐**Wrist/Hand** ☐ **Elbow** ☐ **Neck**

***Date of Injury:**_____

Lien: Do not complete/Must be filled if Workers Comp.

(For patients that do not speak English they MUST bring an interpreter with them.

The appointment will be cancelled if they don't have one with them on the day of the appointment)

Insurance Carrier:_____ **Claim/Case No:** _____

No 3rd Party

***Adjuster Name:**_____ ***Adjuster Number:**_____

***Adjuster Email**: _____ ***Adjuster Fax:** _____

***Claim Address:**_____

*Must be filled out by Attorney

***Patient's Attorney:** _____ ***Assistant/Paralegal:**_____

***Firm:** _____ ***Phone:** _____

Address:_____

***E-mail:** _____ ***Fax No:** _____

Declaration page is **required** if the patient is using anything other than lien.

Notes: _____

The following information needs to be attached with intake form. Appointment will not be made if items are missing.

**** MVA: Police Report, Declaration Page, Insurance Card (if using health insurance) and/or lien.**

If you have any questions please call 404-973-2444 or Email to Manager@performanceatl.com