



Stephanie S. Martin, M.D.

Atlanta: 3280 Howell Mill Rd NW, Ste 205 Atlanta, GA 30327 • Lawrenceville: 631 Professional Dr, Ste 170, Lawrenceville, GA

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
 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