

PATIENT INFORMATION FORM

PATIENT'S NAME _____
Last First Middle

ADDRESS _____ CITY _____ STATE _____ ZIP _____

TELEPHONE _____ SOCIAL SECURITY # _____

SEX __ BIRTHDATE _____ AGE __ MARITAL STATUS M__ S__ W__ D__ Sep__

ANY ALLERGIES TO MEDICINE _____

PATIENT/*PARENT _____ SPOUSE _____

**If patient is a minor*

Birth date _____ Birth date _____

Occupation _____ Occupation _____

Employer _____ Employer _____

Telephone (work) _____ Telephone (work) _____

Social Security # _____ Social Security # _____

NEAREST FRIEND/RELATIVE OTHER THAN SPOUSE WE MAY CONTACT IN CASE OF EMERGENCY:

Name _____ Relationship _____ Phone _____

IF YOU DO NOT HAVE INSURANCE, MAKE ARRANGEMENTS AT DESK.
IF YOU HAVE INSURANCE, PLEASE COMPLETE THE FOLLOWING SECTION:

Medicare # _____

Blue Shield # _____ Subscriber's Name _____

Title XIX (Medicaid) I.D. # _____

HMO _____ Group # _____ I.D. # _____

Other Insurance _____ Policy # _____

If more than one insurance, which one is primary? _____

Is this a Worker's Compensation claim? Yes__ No__ Date of Injury _____

Worker's Comp Ins. Co. & Address _____

Worker's Comp Claim # _____ Employer and address _____

Accident Related? Auto? Other? Date of Accident _____
Yes__ No__ Yes__ No__ Yes__ No__

Accident Insurance Company _____ Policy Holder _____ Policy # _____

Personal Physician/Referring Physician _____ Address _____

I AUTHORIZE THE PROVIDER TO RELEASE TO MY INSURANCE COMPANY ANY MEDICAL INFORMATION NECESSARY TO PROCESS MY CLAIMS. I UNDERSTAND THAT I AM FULLY RESPONSIBLE AND GUARANTEE PAYMENT OF SERVICES RENDERED BY THIS PROVIDER. I HEREBY AUTHORIZE PAYMENT DIRECTLY TO ORTHOPAEDICS, P.C.

Signature of patient (parent if a minor) _____ Date _____