ORTHOPEDIC & SPORTS MEDICINE CENTER

The Strength of Experience

PLEASE COMPLETE ALL QUESTIONS.

Patient's Legal Name: _____ Birth Date: _____

Address: _____
Street *City & State* *Zip Code*

Home Phone: _____ Social Security #: _____

Cell Phone: _____ Age: ____ Sex: ____ Marital Status: S ____ M ____ W ____ D ____ Sep. ____

Employer: _____ Work Phone: _____

Spouse's Name: _____ Work Phone: _____

Who referred you here? _____ Family Doctor: _____

If patient is a minor, please complete:

Mother: _____ Social Security #: _____

Employer: _____ Work Phone: _____

Father: _____ Social Security #: _____

Employer: _____ Work Phone: _____

Patient Lives With: _____

Emergency Contact Information
(If you are not at home, who may we leave a message with?)

Name: _____ Relationship: _____ Phone: _____

Why are you here to see the doctor?

Reason: _____ How did it happen? _____

Date This Began: _____ Is this a 2nd opinion? _____

Workers' Comp.? _____ Sickness or injury? _____

Workers' Comp. Information Only

Phone: _____

Employer: _____

Bill to: _____

_____

Claim #: _____

Authorized by: _____

Office Use Only

W/Comp. G#: _____ 1st Injury

W/Comp. G#: _____ 2nd Injury

Personal G#: _____

Other G#: _____

Insurance Information
(Please complete, regardless of us having copied your card.)

Primary Insurance: _____ Policy #: _____ Group #: _____

Policyholder's Name: _____ SS#: _____ Birth Date: _____

Employer: _____

Secondary Insurance: _____ Policy #: _____ Group #: _____

Policyholder's Name: _____ SS#: _____ Birth Date: _____

Employer: _____

It is understood and agreed that all professional services must be paid for at the time the service is rendered unless prior arrangements are made with the office. Even though an insurance claim may be filed, you are responsible for the total amount of your account and will receive a statement if your account has a balance due. This office cannot accept responsibility for collecting your insurance claim or negotiating a settlement on a disputed claim. I authorize the release of any medical or other information necessary to process a claim and payment of medical benefits to the treating physician.

Patient, Parent, or Guardian's Signature: _____ Date: _____

Form #1 Revised 3-18