Orthopedic Surgery Associates

Name: _____ _____ _____ Today's Date: _____
First Middle Last

Home Address: _____
City: _____ State: _____ Zip: _____
Telephone: (___) _____ Birth date: _____ Age: _____
Email Address: _____ Cell phone number: _____
Occupation: _____ SSN: _____
Employer: _____
Employer's Address: _____
City: _____ State: _____ Zip: _____
Work Phone: (___) _____

Complete this section only if someone other than the patient is financially responsible.

Responsible Party: _____ Relationship to Patient: _____
Home Address: _____
City: _____ State: _____ Zip: _____
Telephone: (___) _____ Birth date: _____ Age: _____
Occupation: _____ SSN: _____
Employer: _____
Employer's Address: _____
City: _____ State: _____ Zip: _____
Work Phone: (___) _____ Cell Phone: (___) _____

Name of Spouse: _____ Birth date: _____ Age: _____
Occupation: _____ SSN: _____
Employer: _____
Employer's Address: _____
City: _____ State: _____ Zip: _____
Employer's Telephone: (___) _____ Cell Phone: (___) _____
Reason for visit: _____ Body Part R or L: _____
Date of Injury: _____
How did injury occur? _____
_____
Place where injury occurred? _____
_____

In case of emergency, contact: _____ Relationship: _____
Home Phone: (___) _____ Work Phone: (___) _____

Name of Family Physician: _____
How did you learn about our practice? _____

(OVER)

Insurance Information:

[Primary Insurance]
Name of Insurance Company:
Address:
City: State: Zip:
Insured's Name: Relationship to insured:
Group Number: Policy ID Number:

[Secondary Insurance]
Name of Insurance Company:
Address:
City: State: Zip:
Insured's Name: Relationship to insured:
Group Number: Policy ID Number:

Did your injury happen on the job? Yes No
Did you report the accident to your employer? Yes No
Is this related to a motor vehicle accident? Yes No
Is this a liability claim? Yes No
**If you answered yes to any of the above questions, additional information is required.

Our office will file a claim to your insurance company for all reimbursable services, to both your primary and secondary carriers. Please remember that you are responsible for all deductible, copay, and non-covered service amounts for insurance companies we are contracted with, If you have an insurance company we do not contract with you are responsible for payment in full. See our complete financial policy regarding contracted, non-contracted, minor, and patients with no insurance coverage policy.

I authorize the release of any medical information necessary to process my claims.

I authorize payment of medical and surgical benefits to Orthopedic Surgery Associates.

Signature of Patient or Responsible Party:_____
Date:

I acknowledge that I have today received a copy of Orthopedic Surgery Associates Notice of Privacy Practices.

_____

Signature *Date* *Print Name*

If signature above is not the patient:_____
(*print name of patient*) (*relationship*)