

ADVANCED ORTHOPEDICS PATIENT INFORMATION

For Office Use Only

Medical Chart Number: _____

Physician: _____

Instructions: All sections must be completed. If not applicable, please indicate as "N/A."

Was this injury sustained on the job? Yes No If so, has a claim been filed with your employer? Yes No

PATIENT INFORMATION

Last Name _____ First Name _____ M.I. _____ Nickname _____ Male Female
Date Of Birth ____/____/____ Age _____ Social Security # _____ - _____ - _____ Marital Status: Single Married Widowed Divorce
Home Address _____ City _____ State _____ Zip _____
Home Phone (____) _____ - _____ Work Phone (____) _____ - _____ Cell Phone (____) _____ - _____ e-mail _____
Employer/School Name _____ Employed: Full Time Part Time Student: Full time Part time
Employer/School Address _____ City _____ State _____ Zip _____ Phone (____) _____
Driver's License # _____ State License Issued _____ Primary Care Physician or Family Physician's Name _____

EMERGENCY CONTACT

Primary Contact _____ Relationship _____ Phone (____) _____ - _____ Hm Wk Cell
Secondary Contact _____ Relationship _____ Phone (____) _____ - _____ Hm Wk Cell

REFERRED BY

Doctor _____ Hospital/Clinic _____ Patient _____
Family Member _____ HMO/PPO Directory _____ Employer _____
Print Advertising _____ Internet _____ School _____
Other _____

PRIMARY INSURANCE

(Please complete blanks with subscribers/primary insurance holders information)

Subscribers Name _____
 Male Female Date Of Birth ____/____/____
Social Security # _____ - _____ - _____
Patient's Relationship to Subscriber _____
Employer _____
Employer's Address _____
City _____ State _____ Zip _____
Insurance Co Name _____
Phone # (____) _____ - _____
Claims Filing Address _____
City _____ State _____ Zip _____
Identification # _____ Group # _____

SECONDARY INSURANCE

(Please complete blanks with subscribers/primary insurance holders information)

Subscribers Name _____
 Male Female Date Of Birth ____/____/____
Social Security # _____ - _____ - _____
Patient's Relationship to Subscriber _____
Employer _____
Employer's Address _____
City _____ State _____ Zip _____
Insurance Co Name _____
Phone # (____) _____ - _____
Claims Filing Address _____
City _____ State _____ Zip _____
Identification # _____ Group # _____

GUARANTOR (if patient is a minor)

Last Name _____ First Name _____ M.I. _____ Male Female
Date Of Birth ____/____/____ SS#: _____ - _____ - _____ Driver's License # _____ State License Issued _____
Relationship to patient _____
Address _____ City _____ State _____ Zip _____
Home Phone (____) _____ - _____ Work Phone (____) _____ - _____ Cell Phone (____) _____ - _____
Have you ever been treated by one of the physicians at Advanced Orthopedics? No Yes
If yes, which physician _____ Approximate date ____/____/____

CONSENT FOR TREATMENT: I hereby consent to necessary examination procedures and/or treatment by my physician, his/her assistants, designees as is necessary in his/her judgment.

FINANCIAL RESPONSIBILITY: I acknowledge full financial responsibility for services rendered. I also understand that payment of charge incurred is due at time of services.

AUTHORIZATION TO RELEASE INFORMATION: I hereby understand and acknowledge I have been provided with a Notice of Privacy Practices. I hereby consent to releasing information for the purposes of treatment, payment, or health care operations.

ASSIGNMENT OF BENEFITS: I hereby authorize my insurance benefits to be paid directly to Advanced Orthopedics. I have read and fully understand the above consent for treatment, financial responsibility, release of medical information and insurance authorization.

Date _____ Signature (patient, parent, or guardian) _____ Relationship _____