FOR OFFICE US ONLY

Orthopaedic Surgeons, P.C. ☐ WC ☐ AUTO ☐ PVT ☐ PER. LIABILITY

PATIENT INFORMATION *(please print)*

PATIENT #_____ DATE OF INJURY _____

LAST NAME _____ FIRST NAME _____INITIAL _____

HOME PHONE _____ WORK PHONE _____ CELL _____

HOME ADDRESS _____

CITY _____ STATE _____ ZIP _____

DATE OF BIRTH _____ SOCIAL SEC # _____ SEX M F MARITAL STATUS S M D W

EMPLOYER NAME & ADDRESS _____

REFERRING PHYSICIAN _____

PRIMARY CARE PHYSICIAN, ADDRESS, PHONE _____

WHOM MAY WE CONTACT IN AN EMERGENCY? _____ PHONE # _____

ATTORNEY NAME (IF APPLICABLE) _____

ATTORNEY ADDRESS (IF APPLICABLE) _____ PHONE # _____

INSURANCE / BILLING INFORMATION * (MUST BE COMPLETED) *

Primary

Insurance Co. _____ Policy/ID # _____ Group # _____

Subscriber's Name _____ Subscriber's Employer _____ Phone # _____

Subscriber's Social Security # _____ Subscriber's Date of Birth _____

Patient's Relationship to Subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other – Explain _____

Subscriber's Address (if different) _____

Secondary

Insurance Co. _____ Policy/ID # _____ Group # _____

Subscriber's Name _____ Subscriber's Employer _____ Phone # _____

Subscriber's Social Security # _____ Subscriber's Date of Birth _____

Patient's Relationship to Subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other – Explain _____

Subscriber's Address (if different) _____

IF WORK RELATED INJURY, PLESE COMPLETE

Employer at Time _____ Occupation _____

Employer Address _____ Phone # _____

_____

Worker's Comp Ins. Carrier _____ Address _____

_____

Worker's Comp. Claim/File#_____ Name & Phone to Verify# _____

_____

IF MOTOR VEHICLE INJURY, PLESE COMPLETE

Automobile Insurance Name _____

Address _____

City, State, Zip _____

Phone # (if known) _____ Adjuster's Name _____

Policy # _____ Claim # _____

Were you: ❑ Driver ❑ Passenger ❑ Front Seat ❑ Rear Seat Wearing a seat belt? ❑ Yes ❑ No

REASON FOR VISIT

Other doctors who have seen you for this problem:

Were X-rays taken pertaining to this visit?

Have you ever had prior injuries to this area or sought medical care for the same problem

prior to the day of injury:

BILLING INFORMATION

All professional services rendered are the responsibility of the patient regardless of insurance coverage. All forms will be completed to obtain insurance payment. I agree to comply with this office, my insurance company and/or my attorney to obtain the necessary paperwork to insure payment. If it is necessary to turn account over to collections after 90 days for non-payment; patient is responsible for bill, collection and/or attorney fees.

AUTHORIZATION TO PAY BENEFITS TO PHYSICIAN:
I hereby authorize payment directly to the undersigned Physician for my charges.

AUTHORIZATION TO RELEASE INFORMATION:

I hereby authorize the undersigned Physician to release any information acquired in the course of my examination to my insurance company in writing or by fax.

MEDICARE STATEMENT

- This claim will be submitted to Medicare for you by our office.
- Medicare may not cover some services which the patient will be responsible to pay. You are responsible for your deductible & coinsurance.

We do: Accept Medicare Assignment.

Signature: _____ Date: _____