specialty orthopedic group

PATIENT INFORMATION FORM

All patient information must be completed in full. Please present your photo ID and insurance card(s) to the receptionist after completing this form. If you have insurance, we will be glad to help you file for any benefits to which you are entitled. However, it remains the responsibility of the individual patient to settle his/her account promptly. To help us file your insurance claim correctly we must make a photocopy or scan an image of your card(s). All co-pay, co-insurance and/or deductible amounts are due at time of service.

Patient Name: _____
Last First Middle Initial Preferred

Social Security #: ___ - ___ - ____ Date of Birth: ___ / ___ / ____ Sex: M F
Month Day Year

Address: _____
Street Apt./Suite City State Zip Code

Mailing Address: _____
Street Apt./Suite City State Zip Code

Race: _____ Marital Status: Single Married Divorced Widowed Seperated

Phone Numbers: (___) _____ (___) _____ (___) _____
Home Cell Work or Alternate

E-mail Address: _____ Place of Employment: _____

Responsible Party Name _____ **Relationship** _____ **Sex: M F**

(If under 18) **Social Security #** _____ **Date of Birth** _____

Emergency Contact Information: _____ (___) _____
Name Phone

Primary Care Provider: _____ Pharmacy: _____

Whom may we thank for referring you to our clinic? _____

Patient (Responsible Party) Signature: _____ Date: _____

If you do not have proof of insurance in the form of an insurance card or if your insurance coverage is through a spouse, parent, or other responsible party, please complete the following:

Primary Insurance Coverage Insurance Company Name: _____

Insured Name: _____ Date of Birth: ___ / ___ / ____
Last First MI Month Day Year

Insured Address: _____
Street Apt./Suite City State Zip Code

ID #: _____ Group #: _____ Social Security #: ___ - ___ - ____

Relationship to Patient: _____ Insured Place of Employment: _____

Secondary Insurance Coverage Insurance Company Name: _____

Insured Name: _____ Date of Birth: ___ / ___ / ____
Last First MI Month Day Year

Insured Address: _____
Street Apt./Suite City State Zip Code

ID #: _____ Group #: _____ Social Security #: ___ - ___ - ____

Relationship to Patient: _____ Insured Place of Employment: _____