ACTIVE ORTHOPAEDICS, P.C.

Please note this paperwork must be filled out in its entirety and given back to staff prior to leaving your appointment*

Patient's Full Name: ___________________________________Age:______Sex:_____Birthdate:________________

Address: ____City:________________ST:_____Zip:___________

Home Phone:_________________________ Cell:_____________________ Work Phone:______________________

Social Security #:______________________Marital Status:________ Who referred you here? _________________

Emergency Contact: ___________________________ Relationship: ______________ Phone #:________________

Family Physician: _________________________________ Address: ______________________________________

***************************SPOUSE/GUARDIAN INFORMATION*********************************

Name: _____________________________ Relationship: ______________ DOB: _____________SSN# ____________

Address: _________________________ City/ST: __________________________ Phone #: ____________________

Employer: ___________________________ Address: _____________________________ Work Phone: __________

*********************************EMPLOYMENT***

Occupation: __________________________________ Employer: ____

Employer Address: ___________________________ City/ST: _____________________ Phone #:_________________

*************************WORK RELATED/AUTO ACCIDENTS************************************

Is this a work related injury? Yes No Is this a motor vehicle accident injury? Yes No

Date of injury/Accident: ________________ File/Claim#: ____

Send claims to: Insurance Company Name: ____

Address: __________________________________City: _______________________ ST: _________ Zip: ___________

Insurance Company Phone: ___________________________ Contact Person: ________________________________

If Work Related: Employer Name & Address: ____

*******************************PLEASE SIGN BELOW**********************************

I AUTHORIZE THE RELEASE OF ANY MEDICAL OR OTHER INFORMATION NECESSARY TO PROCESS MY CLAIM. I ALSO REQUEST PAYMENT OF BENEFITS EITHER TO MYSELF OR TO THE PARTY WHO ACCEPTS ASSIGMENT. IN THE EVENT THAT MY INSURANCE COMPANY DENIES PAYMENT OF A CLAIM IN WHOLE OR PART, I UNDERSTAND THAT I AM RESPONSIBLE FOR PAYMENT IN FULL. COPAY IS DUE AT THE TIME OF SERVICE.

_______________________________________ ____ ____________________

Patient's Signature or Guardian Relationship to patient Today's date