INITIAL PATIENT INFORMATION FORM

Patient Information

Name_______________________________

Address_______________________________

City/ST/Zip _______________________________

Home #____________________(Priority 1, 2, or 3)

Work #____________________(Priority 1, 2, or 3)

Cell #____________________(Priority 1, 2, or 3)

Today's Date ______________

Date of Birth____________________ Age__________

Height____________________ Weight__________

SS # ____________________Sex: ❑Male ❑Female

Marital Status: ❑Married ❑Single ❑Widowed ❑Divorced

Email Address _______________________________

Sometimes we may need to reach you. By providing your phone numbers and/or email address, you consent to receiving such communications, pre-recorded or otherwise using the information you provided.

Referring Physician Information

Name_______________________________

Address_______________________________

Phone____________________ Fax ______________

Primary Care Physician Information

Name_______________________________

Address_______________________________

Phone____________________ Fax ______________

If not physician referred **who may we thank for referring you?** _______________________________

Relationship to referral source: _______________________________

Patient's Employer Information

Name_______________________________

Address_______________________________

Phone_______________________________

Occupation_______________________________

❑Spouse Information ❑Responsible Party Information

Name_______________________________

Address_______________________________

Phone_______________________________

Relationship_______________________________

Who should we contact in case of an emergency? _______________________________

Relationship: ____________________ Phone: _______________________________

How did you become injured?

❑No Injury
Date of injury (mo/day/year) ____________________
❑Sports (which sport)____________________
❑Motor Vehicle accident ❑Work / Job
Where did injury occur: ____________________
____
Briefly describe your injury and what you were doing:
____
____
Is there a workers comp claim? ❑Yes ❑No
Is there a medical pay Auto claim? ❑Yes ❑No

Injury continued

How long have you had symptoms? ______________
Are you currently working? ❑Yes ❑No ❑Retired

❑Normal Job ❑Limited Duty

Please describe your current job limitations ______________

____

Date stopped work (if applicable) ______________

Date returned to work ______________

Name: ______________________________ Date of Birth: ____________

Insurance Information

Do you have Medicare? Yes ❑ No ❑ Medicare ID#: ____________________
Do you have Medicaid? Yes ❑ No ❑ State ID#: ____________________
Insurance Company: ______________________________

Claims Address: ______________________________

ID #: ____________ Group #: ____________ Copay: ____________

Policy Owner: ____________ Policy Owner DOB: ____________
Policy owner's relationship to patient: ________ Is the group insurance through an employer? ________
If yes, give employers name: ______________________________
Is patient covered by another insurance? Yes ❑ No ❑
If yes, list name and address of insurance company: ____________________
Is this a work related injury? Yes ❑ No ❑ If yes, please give workers compensation insurance info.:
Name/Address/Phone#/Claim#: ______________________________

____
Is this an auto related injury? Yes ❑ No ❑ Do you have med pay on YOUR auto policy? Yes ❑ No ❑
If yes, please give auto insurance info. Name/Address/Phone#/Claim# ____________________
____

I certify that the above information is true and correct to the best of my knowledge.

Signature: ____________________ **Date:** ____________________

RELEASE OF INFORMATION:

I hereby authorize release of any information acquired in the course of my examination or treatment to my insurance carrier.

Signed: ____________________ Date: ____________________
Patient or guardian signature

RELEASE OF BENEFITS:

I hereby authorize my insurance benefits to be paid directly to Western Orthopaedics, P.C. I understand I am responsible for all non-covered services.

Signed: ____________________ Date: ____________________
Patient or guardian signature

FINANCIAL AGREEMENT:

I the undersigned, individually obligate myself to the payment of my Western Orthopaedics, PC account incurred by the patient's service(s). I understand that I will be responsible for charges not covered by my health insurance carrier(s). I will be expected to pay my medical bill in full when I am discharged or at the time of provision of medical services, diagnostic services and/or procedures, unless I have made other arrangements with Western Orthopaedics, PC's financial department. Should these bills not be paid, I understand that my account and any of my healthcare information necessary for collection of the bill will be referred to an attorney or collection agency. I will be responsible for paying all attorneys' fees, court costs, and other legal fees, collection agency fees, and costs incurred in collecting my medical payment, together with late fees and interest at the maximum rate allowable by law.

Disclosure

I have read and understand these documents and accept and agree to follow the conditions contained therein.

Signed: ____________________ Date: ____________________
Patient or guardian signature