ORTHOPAEDIC, SPORTS MEDICINE AND REHABILITATION CENTER, P.A.

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www.orthocenter.com

PATIENT INFORMATION

(Please note the information being requested is for the PATIENT)

Patient Name: _____ Sex: M F DOB: _____ Age:____

Home Phone: (____) ____-_____ Cell Phone (____) _____-_____

Home Address: _____ Social Security # _____

City: _____ State: _____ Zip: _____ Marital Status: S M W D

Email address: _____ Race: _____Ethnicity: _____

Employer's Name: _____Phone# _____

IF PATIENT IS UNDER 18 YEARS OF AGE, Responsible Party Information

Responsible Party Name: _____ Sex: M F DOB: _____

Relationship to the patient: _____ Social Security # _____

Billing Address: _____ Phone:(____) _____ -_____

City: _____State:_____Zip:_____

PRIMARY INSURANCE INFORMATION

Subscriber Name: _____ Sex: M F DOB: _____

Subscriber home address: _____

Relationship to patient: _____ Social security # _____

Insurance Name: _____ Policy # _____
Claims Address: _____ Group # _____
City: _____ State:_____ Zip:_____ Phone# (____) _____-_____

PLEASE TURN OVER .....

Patient Information cont'd...

SECONDARY INSURANCE INFORMATION:

Subscriber Name: _____ Sex: M F DOB: _____

Subscriber home address: _____

Relationship to patient: _____ Social security # _____

Insurance Name: _____ Policy # _____
Claims Address: _____ Group # _____
City: _____ State:_____ Zip:_____ Phone# (____) _____-_____

First/Last Name of Primary Care Physician:

_____

First/Last Name of Referring Physician:

_____

Please complete if your visit today is a result of an accident. Type of Accident:

[ ] Auto Accident [ ] Workers Comp Accident

[ ] Slip and Fall Accident [ ] Sports Related Accident [ ] Assault/Battery

Date of Accident: _____/_____/_____ Location of Accident: (City/State) _____

If Sports Related Accident, name of school you attend: _____

Name of Attorney representing you: _____

( ) I authorize the release of any information required in the processing of my health claims

( ) I authorize my insurance benefits to be paid directly to the health care provider

_____ _____/_____/_____
Patient/Guardian Signature Date