



PATIENT NAME: _____ MARITAL: SINGLE MARRIED
LAST FIRST MIDDLE INITIAL STATUS DIVORCED WIDOWED

SEX: _____ BIRTHDATE: _____ AGE: _____ SOCIAL SECURITY # _____

HOME ADDRESS: _____
(DO NOT GIVE P.O. BOX AS ADDRESS) CITY STATE ZIP CODE

HOME PHONE: () _____ WORK PHONE:() _____ E-MAIL _____

EMPLOYER: _____
NAME ADDRESS

PARENT OR GUARDIAN IF PATIENT IS MINOR: _____

REFERRING PHYSICIAN: _____

HOW DID YOU HEAR ABOUT US? FRIEND FAMILY MEMBER PHYSICIAN INTERNET PHONE BOOK OTHER

EMERGENCY CONTACT PERSON: _____ PHONE () _____

PATIENT'S SPOUSE: _____ SPOUSE'S WORK PHONE () _____

SPOUSE'S EMPLOYER _____

ALLERGIES: _____

PRIMARY INSURANCE COMPANY: _____

ADDRESS ON CARD: _____
STREET OR P.O. BOX CITY STATE ZIP CODE

TELEPHONE # ON INSURANCE CARD:() _____

INSURED PARTY: _____ RELATIONSHIP TO PATIENT: FATHER STEPPFATHER
IF OTHER THAN PATIENT MOTHER STEPMOTHER
HUSBAND WIFE

INSURED PARTY'S SEX: _____ INSURED PARTY'S BIRTHDATE: _____

INSURED SOCIAL SECURITY # _____ POLICY GROUP # _____

SECONDARY INSURANCE COMPANY: _____

ADDRESS ON CARD: _____
STREET OR P.O. BOX CITY STATE ZIP CODE

TELEPHONE # ON INSURANCE CARD: () _____

INSURED PARTY: _____ RELATIONSHIP TO PATIENT: FATHER STEPFATHER
IF OTHER THAN PATIENT MOTHER STEPMOTHER
HUSBAND WIFE

INSURED PARTY'S SEX: _____ INSURED PARTY'S BIRTHDATE: _____

INSURED SOCIAL SECURITY # _____ POLICY GROUP # _____

DESCRIPTION OF ONSET/INJURY: _____ DATE OF INJURY: _____

HOW: _____ WHERE: _____

IS THIS COVERED UNDER WORKMEN'S COMPENSATION? _____ **DATE OF INJURY:** _____

HAVE YOU CONTACTED YOUR EMPLOYER? YES _____ NO _____

RESPONSIBLE PARTY: _____

ADDRESS: _____

STREET CITY STATE ZIP CODE

TELEPHONE # () _____

IS THIS INJURY DUE TO AN AUTO ACCIDENT? _____ **DATE OF INJURY:** _____

HAVE YOU CONTACTED YOUR INSURANCE CO. REGARDING THIS ACCIDENT? _____

AUTO INSURANCE COMPANY RESPONSIBLE: _____

BILLING ADDRESS: _____

STREET OR P.O BOX CITY STATE ZIP CODE

TELEPHONE # OF CLAIMS EXAMINER:() _____

POLICY # _____ CLAIM # _____

INSURED PARTY: _____ DATE OF BIRTH: _____

INSURED PARTY'S ADDRESS: _____

STREET CITY STATE ZIP CODE

IS THIS INJURY DUE TO A THIRD PARTY LIABILITY? _____ **DATE OF INJURY:** _____

DO YOU HAVE LEGAL REPRESENTATION FOR THIS TREATMENT? _____

ATTORNEY'S NAME: _____

ATTORNEY'S ADDRESS: _____

STREET CITY STATE ZIP CODE

ATTORNEY'S TELEPHONE # () _____

AUTHORIZATION: I hereby authorize Orthopedic Specialists, S.C. to release any information contained in my medical record to my insurance company, referring physician, and/or primary care doctor. I also hereby authorize for benefits to be paid directly to Orthopedic Specialists, S.C. for medical services I receive from any of the physicians in this practice. I understand that I will be responsible for any unpaid balance, including charges for which a referral was not obtained.

SIGNATURE: _____ DATE: _____