CONSULTING ORTHOPAEDIC ASSOCIATES

PATIENT INFORMATION: (*PLEASE PRINT)*

NAME_____

HOME PHONE_____ CELL PHONE_____ WORK PHONE_____

STREET ADDRESS_____ CITY_____ ST____ ZIP_____

P.O. BOX ADDRESS (if applicable) _____ CITY_____ ST ____ ZIP _____

SOC SEC #_____ AGE_____ BIRTHDATE_____ SEX M F

MARITAL STATUS: SINGLE MARRIED WIDOWED DIVORCED (CIRCLE ONE)

EMPLOYER_____OCCUPATION_____

ADDRESS OF EMPLOYER_____

EMERGENCY CONTACT_____ PHONE_____ RELATIONSHIP_____

PARENT INFORMATION FOR ABOVE PATIENT: *COMPLETE ONLY IF PATIENT IS A MINOR OR COVERED UNDER PARENT'S INSURANCE*

FATHER'S NAME_____ MOTHER'S NAME_____

ADDRESS_____ ADDRESS_____

CITY/ST/ZIP_____ CITY/ST/ZIP_____

HOME PHONE_____ HOME PHONE_____

WORK PHONE_____ WORK PHONE_____

SOC SEC #_____ SOC SEC # _____

DATE OF BIRTH_____ DATE OF BIRTH_____

INSURANCE INFORMATION:

IS TODAY'S CONDITION DUE TO INJURY WORK INJURY AUTO ACCIDENT

DATE OF: INJURY / AUTO ACCIDENT_____

STATE IN WHICH ACCIDENT OCCURRED_____

PRIMARY INSURANCE:

INSURANCE CO. NAME_____

POLICYHOLDER NAME_____ INSURANCE ID#_____

GROUP NAME/#_____ POLICYHOLDER BIRTHDATE_____

PATIENT RELATIONSHIP TO POLICYHOLDER: SELF SPOUSE CHILD OTHER_____

EMPLOYER OF POLICYHOLDER_____

SECONDARY INSURANCE:

INSURANCE CO. NAME_____

POLICYHOLDER NAME_____ INSURANCE ID#_____

GROUP NAME/#_____ POLICYHOLDER BIRTHDATE_____

PATIENT RELATIONSHIP TO POLICYHOLDER: SELF SPOUSE CHILD OTHER_____

EMPLOYER OF POLICYHOLDER_____

NAME OF REFERRING DOCTOR_____ PHONE_____

FAMILY DOCTOR NAME_____ PHONE_____

ADDRESS_____

CITY/ST/ZIP_____

ASSIGNMENT OF BENEFITS/AUTHORIZATION

I HEREBY AUTHORIZE TREATMENT. I AUTHORIZE THIS PROVIDER TO RELEASE INFORMATION ABOUT THESE SERVICES TO MY INSURANCE/MEDICARE CARRIER FOR PAYMENT. I FURTHER AUTHORIZE THAT PAYMENT OF AUTHORIZED BENEFITS BE MADE DIRECTLY TO THIS PROVIDER. I UNDERSTAND THAT I AM FULLY RESPONSIBLE FOR ALL CHARGES INCURRED REGARDLESS OF MY INSURANCE STATUS.

PATIENT SIGNATURE (*If minor-parent/guardian signature*)_____ **DATE**_____