SPECIALTY ORTHOPAEDICS, PLLC

PATIENT INFORMATION

Thank you for choosing our office. In order to serve you properly, we need the following information. All information will be confidential. PLEASE PRINT.

NAME: ____

ADDRESS: ____

CITY/STATE/ZIP: ____

HOME PHONE: _________________ WORK PHONE: ________________ E-MAIL ADDRESS: ___________________

SOCIAL SECURITY NO: ___________________ MARITAL STATUS: ___________ DATE OF BIRTH: ___________

AGE: _____ MALE: _____ FEMALE: _____

EMPLOYER: _______________________________________ OCCUPATION: __________________________________

MOTHER'S FIRST NAME: _________________________FATHER'S FIRST NAME: _________________________

MEDICAL INSURANCE COMPANY: ____

ADDRESS: ____

POLICY #: ____________________________________ GROUP #: ____

POLICY HOLDER: _______________________________ DATE OF BIRTH: _________________________________

PRIMARY/REFERRING PHYSICIAN: ____________________________________ PHONE #: ____________________

ADDRESS: ____

REASON FOR SEEING DOCTOR: ____

IN CASE OF EMERGENCY, NOTIFY: ____

****IF THIS IS **NO FAULT** OR **WORKERS COMPENSATION**:

DATE OF ACCIDENT/INJURY: _____________________ CLAIM/FILE #: ___________________________________

INSURANCE CARRIER: ____

ADDRESS: ____ ARE YOU PRESENTLY WORKNG: YES____ NO____

BRIEF DESCRIPTION OF INCIDENT: ____

AUTHORIZATION: I hereby give my permission to Specialty Orthopaedics, to release any of my (or my child's) medical information to my insurance carrier necessary to process this claim. I accept responsibility for payment of any bills rejected and/or denied by my insurance company. I also authorize payment of insurance benefits otherwise payable to me, directly to the doctor.

SIGNATURE-PATIENT OR GUARDIAN: ____ DATE: _______________