

<b>PATIENT INFORMATION</b>	DATE _____
	ACCT. NO. _____

**How were you referred for this visit?**

(Please circle all that apply)

- |                             |                       |
|-----------------------------|-----------------------|
| Friend/family member        | Saw your advertising: |
| Physician referral          | TV                    |
| Yellow Pages                | Lecture/Presentation  |
| Recommended by the hospital | Newspaper             |
| Web Site                    | Radio                 |
| Other: _____                |                       |

- |  |   |  |
|--|---|--|
| <input type="checkbox"/> Dr. K.M. Baumgarten | <input type="checkbox"/> Dr. E.N. Hermanson | <input type="checkbox"/> Dr. P.K. Rodman   |
| <input type="checkbox"/> Dr. W.O. Carlson    | <input type="checkbox"/> Dr. M.C. Johnson   | <input type="checkbox"/> Dr. C.M. Smith    |
| <input type="checkbox"/> Dr. K.C. Chang      | <input type="checkbox"/> Dr. P.A. Looby     | <input type="checkbox"/> Dr. R.C. Suga     |
| <input type="checkbox"/> Dr. R.B. Curd       | <input type="checkbox"/> Dr. M.J. McKenzie  | <input type="checkbox"/> Dr. E.S. Watson   |
|  | <input type="checkbox"/> Dr. B.R. Plaga     | <input type="checkbox"/> Dr. T.M. Zoellner |

<b>PATIENT NAME (Please Print Full Legal Name)</b> _____ First Middle Initial Last <b>PREFER TO BE CALLED:</b> _____ BIRTHDATE ____/____/____ AGE ____ ( ) Male ( ) Female ADDRESS _____ _____ City State Zip <b>HOME PHONE</b> (____) _____ - _____ <b>CELL PHONE</b> (____) _____ - _____ <b>E-MAIL ADDRESS</b> _____ PATIENT STATUS: ( ) Single ( ) Married ( ) Child ( ) Other _____ (Define) EMPLOYED: ( ) Yes ( ) No OCCUPATION _____ EMPLOYER'S NAME _____ ADDRESS _____ _____ <b>WORK PHONE:</b> (____) _____ - _____ ( ) FULL-TIME STUDENT ( ) PART-TIME STUDENT NAME OF SCHOOL: _____	<b>WHO IS RESPONSIBLE FOR PAYMENT:</b> NAME _____ First Middle Initial Last ADDRESS _____ _____ OCCUPATION _____ EMPLOYER'S NAME _____ WORK PHONE (____) _____ - _____ HOME PHONE (____) _____ - _____ RELATIONSHIP _____ <b>COMPLETE IF MARRIED:</b> NAME OF SPOUSE _____ SPOUSE DATE OF BIRTH: ____/____/____ SPOUSE OCCUPATION _____ SPOUSE EMPLOYER _____ ADDRESS _____ _____ EMPLOYER PHONE: (____) _____ - _____
IS THIS ILLNESS OR INJURY THE RESULT OF: ACCIDENT/ILLNESS THAT OCCURRED AT WORK ( ) AUTO ACCIDENT ( ) ACCIDENT/ILLNESS INVOLVING LIABILITY ( ) ANY OTHER ACCIDENT/INJURY ( ) DATE OF INJURY OR ACCIDENT ____/____/____ STATE IN WHICH ACCIDENT OCCURRED: _____ _____ NAME OF PERSON TO CONTACT IN CASE OF EMERGENCY: _____ WORK PHONE: (____) _____ - _____ HOME PHONE: (____) _____ - _____ ADDRESS: _____ _____ _____ FAMILY DOCTOR _____ First CITY/STATE _____ REFERRING DOCTOR _____ First CITY/STATE _____	<b>FOR ALL MEDICARE PATIENTS</b> <b>MEDICARE ELIGIBILITY BASED ON:</b> ( ) AGE ( ) DISABILITY ( ) END STAGE RENAL DISEASE <b>CIRCLE YES OR NO FOR EACH QUESTION</b> 1. Do you or your spouse work for a company that provides you with health insurance? YES NO 2. Has treatment for this accident or illness been authorized by the Veterans Administration? YES NO 3. Are you entitled to any benefits under the federal black lung program? YES NO 4. Is this patient a nursing home resident? YES NO

**IMPORTANT: PLEASE COMPLETE THE SECOND PAGE**

**PATIENT INFORMATION**
**NAME** \_\_\_\_\_

**MEDICARE #** \_\_\_\_\_ **MEDICAID #** \_\_\_\_\_ **STATE** \_\_\_\_\_

<b>PRIMARY INSURANCE:</b> NAME OF INSURANCE COMPANY: _____ ADDRESS OF INS. CO. _____ _____ <b>POLICYHOLDER:</b> _____ PATIENT RELATIONSHIP TO POLICYHOLDER: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other - PLEASE DEFINE _____ POLICY NUMBER OF <b>INSURED</b> : _____ GROUP <b>NAME</b> _____ GROUP <b>NUMBER</b> _____ DOES YOUR INSURANCE COMPANY REQUIRE PREAUTHORIZATION? <input type="checkbox"/> YES <input type="checkbox"/> NO PHONE NUMBER FOR PREAUTHORIZATION: _____	<b>SECONDARY INSURANCE:</b> NAME OF INSURANCE COMPANY: _____ ADDRESS OF INS. CO. _____ _____ <b>POLICYHOLDER:</b> _____ PATIENT RELATIONSHIP TO POLICYHOLDER: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other - PLEASE DEFINE _____ POLICY NUMBER OF <b>INSURED</b> : _____ GROUP <b>NAME</b> _____ GROUP <b>NUMBER</b> _____ DOES YOUR INSURANCE COMPANY REQUIRE PREAUTHORIZATION? <input type="checkbox"/> YES <input type="checkbox"/> NO PHONE NUMBER FOR PREAUTHORIZATION: _____
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**AUTHORIZATION TO PAY ORTHOPEDIC INSTITUTE, P.C.**

I authorize payment directly to Orthopedic Institute, P.C. of benefits payable under this policy. I understand that I will be financially responsible to Orthopedic Institute, P.C. for any charges not covered by this policy.

It is the objective of this office to provide our patients with the best available care and facilities at a reasonable cost. In an effort to eliminate the expense of billing and collection, we ask that you pay for these services as they are rendered.

A service charge of 1.2% will be added for accounts over 90 days past due.

If you have insurance, please understand that this is an agreement between you and your insurance company to pay certain amounts for medical care. Our bill for services is an agreement between you and us.

If unusual circumstances should make it impossible to meet our credit terms, please call or personally discuss the matter with our credit manager. This will avoid misunderstandings and enable you to keep your account in good standing.

\_\_\_\_\_  
 Signature

\_\_\_\_\_  
 Relationship (Parent, Foster Parent, Attorney, etc.)

\_\_\_\_\_  
 Date