

Patient Information

Last Name _____ First Name _____ Middle Initial _____

Address _____ City _____ State _____ Zip Code _____

Email _____ Phone _____ Cell _____

Single _____ Married _____ Other _____ Date of Birth _____

Sex _____ Age _____ Social Security # _____

Parent Name _____ Referring Docotor _____

Fax # _____

Is this visit the result of a work accident _____ Motor Vehicle Accident _____

Date of Injury _____

Workers Comp/ Motor Vehicle Information:

Insurance Co _____ Address _____

Telephone # _____ Fax # _____

Claim# _____ Adjusters Name _____

Phone# _____ Fax# _____

Name of Policy Holder _____

Primary Health Insurance _____

ID# _____ Group# _____

Name of the Insured _____ Relationship to patient _____

Insured SS# _____ Insured DOB _____

Secondary Insurance _____

ID# _____ Group# _____

Name of the Insured _____ Relationship to patient _____

Insured SS# _____ Insured DOB _____

I certify that the information I have provided is accurate. I authorize the release of medical or other information required to process this claim. I understand I am responsible for any unpaid balances. I understand it is my responsibility to obtain any necessary referrals required by my insurance plan **prior** to being treated by Orthopaedics Unlimited. All copayments are required at time of visit; there is a \$25.00 fee for returned checks.

Signature: _____

My insurance carrier is _____ I have been informed that Orthopaedics Unlimited is a non-participating provider. All unpaid deductible amounts are required prior to treatment. A bill will be submitted to your insurance Co. on your behalf. **As the patient , and a “covered person”under my health insurance policy, I direct my insurance carrier that all checks in payment for medical services provided by Orthopaedics Unlimited , shall be made payable to the practice only, and that such payment checks shall not also be made payable to me.”**

Signature: _____

Assignment of Benefits:

I irrevocably assign to Orthopaedics Unlimited all my rights and benefits under any insurance contracts for payment of services rendered to me by Orthopaedics Unlimited. I irrevocably authorize all information regarding my benefits under any insurance policy relating to any claims by Orthopaedics Unlimited to be released to Orthopaedics Unlimited. I irrevocably authorize Orthopaedics Unlimited to file insurance claims on my behalf for services rendered to me. **I irrevocably direct that all payments are made out to and go directly to Orthopaedics Unlimited only.** I irrevocably authorize Orthopaedics Unlimited to act on my behalf and report any suspected violations or improper claims practices to the proper regulatory authorities. This assignment of benefits has been explained to my full satisfaction and I understand its nature and effect.

Signature: _____

I have read and understood the privacy policy of Orthopaedics Unlimited, I do/do not grant permission to release my medical information.

Name of person authorized to receive your medical information

Signature of Patient : _____

Date: _____

List current medications;

Are you pregnant ? _____ Do you smoke? _____ Drink alcoholic
beverages _____ How much _____

List any allergies: _____
Allergies to medication : _____

Have you ever had the following medical conditions?

Abnormal breathing	Y N	High Blood Pressure	Y N
Alcohol/ Drug abuse	Y N	HIV/Aids	Y N
Arthritis	Y N	Hospitalized	Y N
Artificial joints	Y N	Kidney problems	Y N
Valve replacement	Y N	Liver Disease	Y N
Tuberculosis	Y N	Low Blood Pressure	Y N
Cancer/Chemotherapy	Y N	Mitral Valve	Y N
Congenital heart disease	Y N	Pacemaker	Y N
Diabetes	Y N	Psychiatric Problems	Y N
Emphysema	Y N	Radiation Treatment	Y N
Fainting Spells	Y N	Rheumatic/ scarlet fever	Y N
Fever	Y N	Shingles	Y N
Frequent Headaches	Y N	Sickle Cell Anemia	Y N
Glaucoma	Y N	Sinus Pressure	Y N
Hay Fever	Y N	Stroke	Y N
Heart Surgery	Y N		
Hemophilia	Y N		
Hepatitis	Y N		
Herpes/ Fever blisters	Y N		

All of these questions have been answered completely and truthfully to the best of my knowledge.

Patient Signature : _____

Physician Review : _____