

PATIENT INFORMATION

Last Name _____ First Name _____ Middle Initial _____

Address _____ City/State _____ Zip _____

Telephone # () _____ Business # () _____

Single _____ Married _____ Other _____ Date of Birth _____

Sex _____ Age _____ Social Security # _____

IF PATIENT IS A MINOR PLEASE STATE PARENTS NAME _____

REFERRING DOCTOR: _____

IS THIS VISIT THE RESULT OF A WORK ACCIDENT? _____ OR
MOTOR VEHICLE ACCIDENT? _____

IF YES, WHAT IS THE DATE OF INJURY? _____

WORKERS COMP/ MOTOR VEHICLE INSURANCE INFORMATION

Insurance Company _____ Address _____

City _____ State _____ Zip _____ Telephone # () _____

Adjuster's Name _____ Policy # _____

Claim # _____

Name and address of responsible party, if different from above _____

Name and address of employer _____

PRIMARY HEALTH INSURANCE INFORMATION

Insurance company _____ I.D. # _____

Group # _____ Address _____

Name of Insured (if different from patient) _____

Relationship to patient _____

Insured's social security # _____ Insured's date of birth _____

SECONDARY HEALTH INSURANCE INFORMATION

Insurance company _____ I.D. # _____

Group # _____ Address _____

Name of insured (if different from patient) _____

Relationship to patient _____

Insured's social security # _____ Insured's date of birth _____

I certify that the information that I have provided is accurate. I authorize the release of medical or other information necessary to process this claim. I understand that I am responsible for any unpaid balances. I also understand that it is my responsibility to obtain the necessary referrals (if appropriate) prior to being treated by Orthopedics Unlimited. All co-payments are due at the time of your visit. **THERE WILL BE A \$25.00 FEE FOR ALL RETURNED CHECKS.**

Patient's Signature: _____ Date: _____

If a minor, Parent/Guardian's Signature: _____ Date: _____