

Orthopaedic Associates, P.A.

Patient Information

First: _____ Middle: _____ Last: _____
Address _____ City: _____ State: _____ Zip: _____
Home Phone #: _____ Cell Phone #: _____ ☺EMAIL: _____
Date of Birth: _____ Age: _____ SS#: _____ Gender: _____
Marital Status: _____ Race: _____ Is the Patient a Student: Yes No

Complete ONLY if Patient is a Minor

Parent / Responsible Person: _____
Address: _____ Phone #: _____ Date of Birth: _____ SS#: _____

Emergency Contact Information is REQUIRED:

Emergency Contact Person: _____ Relationship: _____ Phone #: _____
Patient's Employer or School: _____ Work Phone #: _____
Occupation: _____ Address: _____ Full Time Part-time

Spouse's Name: _____ Spouse's Date of Birth: _____ Spouse's SS #: _____
Spouse's Employer: _____ Spouse's Work Phone #: _____

Primary Insurance Information

Insurance Company: _____ Insured's Name: _____
Insured's SS#: _____ Insured's DOB: _____ Insured's Group / Policy #: _____

Secondary Insurance / Supplemental Insurance

Insurance Company: _____ Insured's Name: _____
Insured's SS #: _____ Insured's DOB: _____ Insured's Group / Policy #: _____

Injured OR Painful Area: _____ Right Left **Date of Injury OR Onset of Pain:** _____

If an Accident, was it: WORK RELATED AUTOMOBILE ACCIDENT OTHER INJURY: _____

Referred By: (Physician, Hospital, ER, Friend, etc.): _____

Payment Method for co-pay, co-ins, deductible: Cash Check Credit Card (Visa/MasterCard) Care Credit

I certify the above information is correct to the best of my knowledge. I also understand that I am financially responsible for all charges whether or not covered by insurance. I hereby assign, transfer, and set over to Orthopaedic Associates all of my rights, title, and interest to my medical reimbursement benefits under insurance(s) policy listed above. Thus, if the account balance is not satisfied within 60 days after the first notification, the account may be referred to a collection agency. I authorize the release of information to my referring or family physician and/or that which is necessary to file claims to the insurance carrier and the billing of my account for payment. I understand that you may be transmitting any records electronically, and I absolve all parties of any liability to such of said records.

Signature: _____ **Date:** _____