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

* If a Prescription should be given today, which Pharmacy & Location:____

Pharmacy Benefits Carrier :____**(Please give card to Receptionist)**

Patient's Employer or School: _________________________ Work Phone #: ___________________________________

Occupation: __________________________ ☐ Full Time ☐ Part-time

What body part is injured or painful:__________________ ☐ Right ☐ Left Date of Injury ____________________

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

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

Who is your Primary Care Physician: ____

Patients Spouse's Name**:** _______________________ Spouse's Date of Birth: _________ Spouse's SS #:____________

Patients Spouse's Employer: _____________________ Spouse's Work Phone #: _________________________________

If the Patient is a Minor – provide guardian information:

Parent / Responsible Person: ____

Address: _________________________ *Phone #:*__________________ *Date of Birth:* ________ *SS#:* _____________

REQUIRED:

Emergency Contact Person: __________________________ Relationship: _____________ Phone #: _______________

Does the patient have Advance Directives? (Living Will) ☐ YES ☐ NO

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 #: ___________________

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. I understand that OA has the right to refuse or accept assignment of such benefit. 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:** ____________________________