Patient Information

Name: ______________________________ SS#: ______________________
(Last) (First) (MI)

Home Address: ____
(Street) (City) (State) (Zip)

Mailing Address: ____________________________________ Home Phone: ______________

Cell Phone: ______________ Birthdate: __________ Age: _____ Sex: M F Marital Status: CH S M D W

Employer: ______________________________ Work Phone: ______________________

Employer Address: ____
(Street) (City) (State) (Zip)

Email Address: ____________________ Preferred Pharmacy (include city) : ____________________

Emergency Contact: ____
(Name) (Relationship) (Phone #)

Family Physician: ______________________________ Phone#: ____________________

Address: ____
(Street) (City) (State) (Zip)

Please list any allergies the patient may have: ____________________________________

Please provide name(s) of any individuals with whom we may discuss your medical care:____________________
Relationship

How did you hear about our practice? ____________________________________

If the patient is a child, please provide the following information for the parent responsible for the bill:

Name: ____________________ SS#: ______________ Birthdate: ______________

Address: ____
* If different from child

Home Phone: __________ Employer: ____________________ Work Phone: ______________

Primary Insurance

Insurance Company: ____________________

Claim Address: ____________________
(If it does not appear on card)

Policy Holder: ____________________

SS#: ______________ Birthdate: __________

Employer: ____________________

Relationship to patient: ____________________

Secondary Insurance

Insurance Company: ____________________

Claim Address: ____________________
(If it does not appear on card)

Policy Holder: ____________________

SS#: ______________ Birthdate: __________

Employer: ____________________

Relationship to patient:____________________

I authorize the release of any medical information necessary to process my claims.
I authorize payment of medical benefits directly to the physician for services rendered.
I understand that I am responsible for all co-payments, coinsurance and services deemed “non-covered” by my insurance.
I authorize my physician to act as my agent in assisting me to obtain payment from my insurance companies.
I acknowledge that I have received and/or reviewed a copy of Precision Orthopaedic Specialties, Inc’s Notice of Privacy Practices.

______________________________ ______________
(Signature of patient) (Date)

______________________________ ______________
(Signature of legal guardian if patient is a minor) (Date)