PATIENT INFORMATION SHEET 2014

Today's date:_____ **Account#:**_____ | TYPE | OFFICE | DOCTOR |

PATIENT INFORMATION

Patient name:_____ **Social Security#:**_____

Patient address:_____

City/State:_____ZIP:_____ Home phone#:_____

Occupation:_____ Mobile-Phone#:_____

Patient's sex:_____ Age _____ Work Phone#:_____

Marital status: Single () Married () Separated () Widowed () Divorced () **Date of Birth:**_____

Email Address:_____

Preferred Language: _____Ethnicity: Hispanic___Non- Hispanic_____Race _____

Employer name and address:_____

Primary care physician (& phone #):_____

Referred by:_____ **Preferred Pharmacy (location)**:_____

Emergency Contact (name & number):_____

Relationship to patient: Spouse () Child () other ()

ACCIDENT/INJURY INFORMATION: Type of injury:_____Place of injury:_____Date of injury:_____

Was this due to an auto accident? Yes () No ()- If yes, please complete the Workers Comp/ Third Party Information form (#6)

Will this claim be covered by Workman's compensation? Yes () No ()-If yes, please complete the Workers Comp/Third Party Information form (#6)

INSURANCE INFORMATION**fill in and we will make a copy of your insurance card**

Policy Holder Name:_____Social Security:_____
Policy Holder Date of Birth: _____ Relationship to Patient: _____
Ins. Co. Name:_____
Ins. Co. Address (include city/state & zip):_____
Group #:_____ Policy#:_____
Medicare #:_____ Medicaid#:_____

SECONDARY INSURANCE INFORMATION**fill in and we will make a copy of your insurance card**

Policy Holder Name:_____Social Security:_____
Policy Holder Date of Birth: _____ Relationship to Patient: _____
Ins. Co. Name:_____
Ins. Co. Address (include city/state & zip):_____
Group #:_____ Policy#:_____
Medicare #:_____ Medicaid#:_____

RESPONSIBLE PARTY INFORMATION

Name:_____ Relationship to patient:_____
Address:_____ Home phone#:_____
City/State:_____ ZIP:_____ Occupation:_____
Employer:_____ Emp. Phone#:_____

I hereby assign all medical benefits to which I am entitled to ORTHOPAEDIC BONE & JOINT SPECIALISTS, P.A. I understand that I am financially responsible for all charges, whether or not paid by said insurance company. I hereby authorize said assignee to release any information to determine these benefits for related services.

PATIENT SIGNATURE OR AUTHORIZED PERSON:_____