Date _____

Medical Records

PATIENT

Patient Name: _____ Age: _____ Sex: _____ Birthdate: _____
Patient SSN # _____ Phone # - Home: _____ Work: _____ Cell: _____
Home Address: _____ Email Address: _____
City _____ State _____ Zip _____
Who is responsible for the Bill? ❑ Patient ❑ Spouse ❑ Father ❑ Mother
Name of person responsible (if not patient) _____
In case of emergency notify: _____ Telephone _____
Family's Cell Phones (Name and Number) _____

SPOUSE

Marital Status: ❑ Married ❑ Single ❑ Divorced ❑ Widowed
Spouse's Name _____ Spouse's SSN # _____
Spouse's Employer _____

EMPLOYER

Employer of Patient or Responsible Party _____
Employer Address _____
City _____ State _____ Zip _____
Employer Phone _____

CURRENT MEDICAL PROBLEM

Is your current medical problem the result of an Accident? ❑ Yes ❑ No
If an Accident, were you injured at ❑ Work ❑ School ❑ Auto ❑ Home ❑ Other
Date of Injury: _____ If not an Accident, date which symptoms began: _____

PRIMARY INSURANCE

My primary insurance is: ❑ Private Insurance ❑ Workers Comp ❑ Medicare ❑ School Insurance ❑ None
Insurance Co. or Workers Comp Carrier Name: _____
Name of insured as it appers on Insurance ID card: _____ Effective Date: _____
Last First MI
Birthdate of insured: _____
ID # or Contract #: _____ Group # or Medicare #: _____
Insurance Company Address _____
City _____ State _____ Zip _____

SECONDARY INSURANCE

Secondary Insurance Company Name: _____
Name of insured as it appers on card: _____
Effective Date: _____
Birthdate of insured: _____
ID # or Contract #: _____ Group # or Medicare #: _____
Insurance Company Address _____
City _____ State _____ Zip _____

I hereby request and authorize my insurance companies and/or Medicare to pay directly to OrthoSurgeons any proceeds payable under the terms of my policy and/or policies. I understand and agree any unpaid balance not covered by this policy is my responibility and will be paid in full by me. I also give my consent to OrthoSurgeons to release medical information to my insurance companies and/or Health Care Financing Administration.

Signed (If minor, reponsible party must sign) _____ Date _____