**CENTER FOR ORTHOPEDIC EXCELLENCE – PATIENT INFORMATION**

Patient **Full** Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_ SSN: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Mailing Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_State\_\_\_\_\_\_ Zip\_\_\_\_\_\_\_\_\_

Home Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell Ph. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Email \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Marital Status S M D W PCP/ Family Doctor \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Employed? FT PT Retired Not Employed Occupation \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Employer \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work Number \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Emergency Contact Phone Number Relationship

Emergency Contact Phone Number Relationship

**If Under 18**-Parent/Guardian/Responsible Party

Home Phone Soc. Sec. # Birth Date Mailing Address (If Different From Patient’s)

Is This Visit A Result Of An Accident? Y N Describe Injury

Date & Place Of Injury Auto Accident **Y** or **N** Work Related **Y** or **N**

**Please provide all claim information in order for us to bill for services provided. If you do not have this information you will need to reschedule. We do not bill your private health insurance for work related injuries.**

\* **PLEASE GIVE THE RECEPTIONIST YOUR INSURANCE CARDS TO PHOTOCOPY**

**Primary Insurance Company** Subscriber Relationship Birth Date Employer ID # Group # Do You Have A Co-Pay? Y N $

**Secondary Insurance Company** Subscriber

Relationship Birth Date Employer ID # Group # Do You Have A Co-Pay? Y N $

I hereby authorize Center for Orthopedic Excellence to apply for benefits on my behalf and/or my dependants for services rendered. I request that payment by my insurance company/companies be made directly to Center for Orthopedic Excellence.

I certify that the information I have reported with regard to my insurance coverage is correct. I authorize the release of any necessary information, including medical information for this or any related claim, to process my claims. I permit a copy of this authorization to be used in place of the original. Either my insurance company or I may revoke this authorization at any time in writing.

I agree to promptly pay all charges when billed for medical services rendered and accept legal responsibility for any and all charges for the patient named above.

X

# Patient/Guardian/Responsible Party Relationship To Patient Date