



Orthopaedic Associates, P.S.C.

Please complete and return this form to the receptionist. We will file with your insurance company if you provide us with complete insurance information.

PATIENT INFORMATION				FILL IN IF PATIENT IS A MINOR	
Patient's name (First, Middle, Last)				Father's Name (First, Middle, Last)	
Patient's Address				Soc. Sec. No.	
City, State				Employer	
Zip				Employer's Phone	
Date of Birth		Age	Sex	Occupation	
Soc. Sec. No.		Employer's Address (Street)			
Marital Status		Home Phone	Work Phone	City, State	
Zip		Zip			
Are You: <input type="checkbox"/> Actively Employed <input type="checkbox"/> Retired (circle one)				Mother's Name (First, Middle, Last)	
Employer				Soc. Sec. No.	
Employer's Address (Street)				Employer	
City, State				Employer's Phone	
Zip				Occupation	
Occupation (Indicate if Student)				Employer's Address	
Nearest Relative/Friend (not in same household)				City, State	
Address				Zip	
Phone				INSURANCE	
City, State				PRIMARY INSURANCE	
Zip				Name of Policyholder	
Referred by		Phone		Birthdate	
Address				Insurance Address	
City, State				City, State	
Zip				Zip	
Family Doctor or Pediatrician		Phone		Policy Number	
Address				Group Number	
City, State				SECONDARY INSURANCE	
Zip				Name of Policyholder	
FILL IN FOR HUSBAND OR WIFE				Birthdate	
Spouse's Name				Insurance Address	
Is Spouse: <input type="checkbox"/> Actively Employed <input type="checkbox"/> Retired (circle one)		Soc. Sec. No.		City, State	
Employer		Employer's Phone		Zip	
Occupation				Policy Number	
Employer Address (Street)				Group Number	
City, State				If Accident Related	
Zip				Work Injury yes no	
RELEASE INFORMATION: I hereby authorize the release of medical information to my family doctor and/or referring doctor and to insurance carriers concerning my illness and treatment. I hereby request payment of benefits to Orthopaedic Associates, P.S.C. I understand I am responsible for any amount not covered by insurance. Doctor: _____				Automobile Injury yes no	
SIGNATURE PATIENT OR GUARDIAN _____				Date of Accident and Description	
DATE _____ ACCOUNT # _____					

RELEASE INFORMATION: I hereby authorize the release of medical information to my family doctor and/or referring doctor and to insurance carriers concerning my illness and treatment. I hereby request payment of benefits to Orthopaedic Associates, P.S.C. I understand I am responsible for any amount not covered by insurance. Doctor: _____

SIGNATURE PATIENT OR GUARDIAN _____

DATE _____ ACCOUNT # _____