

PATIENT INFORMATION RECORD

DATE RECORD PRINTED: ___/___/___

To See Doctor: _____

Primary Care Physician: _____

Acct # _____ E-mail _____

Patient's Legal Name _____
First Middle Last

Patient's Address _____

City: _____ State: _____ Zip: _____

Age ___ Sex ___ Social Security# ___ - ___ - ___ Date of Birth ___/___/___

Home Phone # _____

Business Phone # _____ Ext: _____

Employed By _____ Occupation _____

Address _____ City _____ State _____ Zip _____

How Did You Hear About This Office _____

Date of Injury ___/___/___ Was this an accident? ___ If so was this work related? ___

Reason For Visit _____

Name of Spouse, Parent, or Guardian
(Emergency Notification) _____
First Middle Last

Employed By _____ Occupation _____

Business Address _____

Business Phone # _____ Ext _____ Relationship to Patient _____

INSURANCE INFORMATION:

(PLEASE BRING YOUR INSURANCE IDENTIFICATION CARD TO THE RECEPTIONIST SO WE MAY MAKE A COPY)

Primary Insurance Company: _____ **Insured's SS#** ____ - ____ - ____

Policy Holder's Name _____ **Relationship to Patient** _____ **DOB** ____ - ____ - ____

Group # _____ **ID Number or Policy Number** _____

Employed By _____

Business Address _____ **City** _____ **State** _____ **Zip** _____

Business Phone # _____ **Ext** _____

Secondary Insurance Company: _____ **Insured's SS#** ____ - ____ - ____

Policy Holder's Name _____ **Relationship to Patient** _____ **DOB** ____ - ____ - ____

Group # _____ **ID Number or Policy Number** _____

Employed By _____

Business Address _____ **City** _____ **State** _____ **Zip** _____

Business Phone # _____ **Ext** _____

AUTHORIZATION OF TREATMENT, ASSIGNMENT OF BENEFITS AND RELEASE OF INFORMATION

I hereby authorize payment of benefits directly to FULLERTON ORTHOPAEDIC SURGERY of the surgical and/or medical benefits if any, otherwise payable to me for their service. Insurance authorization, verification, and co-payments are the responsibility of the member. I understand that if my insurance benefits and/ or eligibility are not approved by my health plan, then I am financially responsible and agree to pay for all charges related to services provided to the patient. This waiver will remain valid for this day forward, to include all future services, relating to the above patient. I am also responsible for any collection for legal costs incurred should such cost be necessary of non-payment.

I hereby authorize the release of any medical or other information necessary for the processing of insurance benefits or medical and/or surgical services rendered.

I hereby authorize treatment by FULLERTON ORTHOPAEDIC SURGERY.

Signature of Patient, Parent, Guardian or Insured

Date