PREMIER ORTHOPEDICS

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Date: _____ WELCOME TO OUR OFFICE! Referred By: _____
Primary Care Physician: _____

Please print **ALL** information requested within boxes. Form must be **COMPLETE** in order for us to set up your records before the Doctor sees you.

Name: _____ Nick-Name: _____
Last First Middle Initial

Sex: ❑ M ❑ F Date of Birth: _____ Age: _____ Marital Status: ❑ S ❑ M ❑ D ❑ W ❑ Sep

SSN: _____ Drivers License #: _____ State _____

Home Address: _____ City, State, Zip: _____

Home Phone: _____ Cell Phone: _____ Alternate Phone: _____

Employer: _____ Business Phone: _____

Occupation: _____ Years Employed _____

Emergency Contact: _____ Relation to Patient: _____

Emergency Address: _____ Phone Number: _____

MEDICAL INFORMATION

Reason for today's visit: _____ ❑ Second Opinion ❑ Evaluation ❑ Treatment

Date of Injury: _____ Date first consulted a physician: _____

Was the injury work related (Y/N) _____ Due to Auto Accident (Y/N) _____

Current Medications _____

Allergies to medication: ❑ Yes ❑ No If yes, which one(s) _____

RESPONSIBLE PARTY

Name: _____ Date of Birth: _____ SSN: _____

Address: _____

City, State, Zip Code: _____

Home Phone: _____ Relationship to Patient: _____

Employer: _____ Occupation: _____ Yrs. Empl. _____

Business Address: _____ Business Phone: _____

City, State, Zip Code: _____

INSURANCE INFORMATION

PRIMARY CARRIER:	SECONDARY CARRIER:
Address:	Address:
City, State, Zip Code:	City, State, Zip Code:
Phone:	Phone:
I.D. #:	I.D. #:
Group #: Plan #:	Group #: Plan #:
Coverage: ❑ Spouse ❑ Dependents ❑ Copay Amount $	Coverage: ❑ Spouse ❑ Dependents ❑ Copay Amount $

Thank you for choosing us as your health care provider. We are committed to providing you with the best possible care. Payment for services is due at the time services are rendered. We accept cash, checks, MasterCard and Visa. A 5% discount will apply to your charges when your account is PAID IN FULL by cash or check at the time of service.

FINANCIAL AGREEMENT AND AUTHORIZATION FOR TREATMENT AND RELEASE OF MEDICAL INFORMATION

I authorize treatment of the person named above and agree to pay all fees and charges for such treatment. I understand that all charges are due and payable at the time of service. I am also aware that if insurance does not cover services, or if the physician does not accept assignment, I am responsible for all charges. I authorize payment of insurance benefits directly to Premier Orthopedics. I hereby authorize the release of pertinent medical information to insurance carriers. I also authorize Premier Orthopedics to leave messages for me via telephone for reasons of treatment, scheduling of appointments, testing or surgeries.

SIGNATURE: _____ DATE: _____