PATIENT INFORMATION

Name____ Home Phone # (   )_________________

Sex: ☐M ☐F Age _____ Date of Birth ___/___/___ Cell# (   )___________Work #(   )___________

Social Security # ______________________ ☐Single ☐Married ☐Widow ☐Divorced ☐Child

Home Address _______________________ City _____________________ State ______ Zip _______

Email Address____________________________________

Primary Care Physician (PCP)_________________________________Ph#_______________________

PCP address_____________________________________City______________ST_____Zip_________

Pharmacy name & phone number ____

Patients Employer _____________________________ Occupation______________________________

Reason for visit / What part of the body?__________________________________ ☐**Left** ☐**Right**

Date of injury or when problem began ___/___/___ (A date *must* be entered, estimate if necessary)

Work or Auto Accident? ☐ YES (if yes, see receptionist for additional form)

INSURANCE INFORMATION - (complete if insurance is not in the patient's name)

Subscribers name (name that the insurance is under)____

Relationship to Patient ___________ Date of birth of subscriber ___/___/___ Soc Sec #_____________

Address (if different from patient's) __________________________________Phone #______________

Insured's Employer ____________________ Insurance Company Name__________________________

ADDITIONAL HEALTH INSURANCE INFORMATION

Is the patient covered by additional health insurance? (if yes, please fill out this section)

Subscriber Name _________________________________ Relationship to patient ________________

Date of birth ___/____/___ Social Security # _______________ Sex: ☐M ☐ F

Address (if different from patient's) ________________________________ Phone # _______________

Insured's Employer _________________________ Insurance Company Name_____________________

ASSIGNMENT AND RELEASE

I, the undersigned, certify that I (or my dependent) have insurance coverage with the Insurance company(s) stated & assign directly to Troy Orthopedic Associates all insurance benefits, if any, otherwise payable to me for any services rendered. I understand that I am financially responsible for all charges not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

_______________________________________ ________________________ ______________

Patient / Parent-Guardian Signature Relationship Date