

PATIENT INFORMATION FORM

PATIENT INFORMATION SECTION

CIRCLE ONE MR MRS MISS MS	LAST NAME	FIRST NAME	MAIDEN NAME	BIRTHDATE / /	AGE
STREET ADDRESS				<input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	
CITY		STATE	ZIP CODE	SOCIAL SECURITY NUMBER	
HOME PHONE		WORK PHONE		DRIVERS LICENSE NO.	
WHO REFERRED YOU TO OUR OFFICE?			HAVE YOU BEEN TREATED BY ANY DOCTOR IN THIS PRACTICE BEFORE? <input type="checkbox"/> YES <input type="checkbox"/> NO WHEN?		
NAME AND ADDRESS OF FAMILY DOCTOR					
EMPLOYER NAME			OCCUPATION		
EMPLOYER'S ADDRESS		CITY	STATE	ZIP CODE	
SPOUSE OR PARENT'S NAME		SOCIAL SECURITY NUMBER	RELATIONSHIP TO PATIENT	<input type="checkbox"/> PARENT <input type="checkbox"/> SPOUSE <input type="checkbox"/> OTHER	
ADDRESS OF SPOUSE IF DIFFERENT		CITY	STATE	ZIP CODE	

EMERGENCY CONTACT

NAME	RELATIONSHIP	HOME PHONE	WORK PHONE
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INSURANCE INFORMATION - PLEASE PRESENT INSURANCE CARDS TO RECEPTIONIST

PRIMARY INSURANCE COMPANY			SECONDARY INSURANCE COMPANY		
MAILING ADDRESS		CITY	STATE	MAILING ADDRESS	
		CITY	STATE		
SUBSCRIBER	RELATIONSHIP / D.O.B.		SUBSCRIBER	RELATIONSHIP / D.O.B.	
I.D. NUMBER	GROUP NUMBER		I.D. NUMBER	GROUP NUMBER	

HISTORY OF PROBLEM

PLEASE EXPLAIN BRIEFLY WHY YOU ARE SEEING THE DOCTOR, SPECIFY LEFT OR RIGHT

FIRST SYMPTOM OR DATE OF INJURY

HOW DID INJURY OCCUR & WHEN?

WAS AN AUTOMOBILE INVOLVED? <input type="checkbox"/> YES <input type="checkbox"/> NO	DATE OF ACCIDENT	NAME OF ATTORNEY	PHONE
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WERE YOU INJURED ON THE JOB? YES NO *IF YES, COMPLETE WORK RELATED INJURIES SECTION.*

WORK RELATED INJURIES

NAME OF COMPENSATION INSURANCE CARRIER		ADJUSTER'S NAME - PHONE NUMBER	
INSURANCE CARRIER ADDRESS		CITY	STATE ZIP CODE
NAME OF EMPLOYER (AT TIME OF INJURY)		NAME OF SUPERVISOR	
ADDRESS		SUPERVISORS PHONE NO.	
NURSE CASE MANAGER		PHONE	
INDUSTRIAL CLAIM & CASE NO.		DATE OF INJURY	

RELEASE OF MEDICAL INFORMATION AND ASSIGNMENT OF BENEFITS

I hereby authorize WEBSTER ORTHOPAEDIC MEDICAL GROUP to release information regarding my treatment or examination rendered to me for medical or surgical care to insurance company(s) or its representatives. I also authorize payment to be made directly to WEBSTER ORTHOPAEDIC MEDICAL GROUP in the amount due for all medical and/or surgical charges for myself or my eligible dependents. I understand that I am financially responsible for any amounts not covered or paid by my insurance company(s).

SIGNATURE **X** _____ DATE _____

OVER - PLEASE COMPLETE BACK OF FORM

To our medicare patients: Please sign Beneficiary Authorization on reverse side

MEDICARE PATIENTS ONLY

LIFETIME BENEFICIARY AUTHORIZATION

(NAME OF BENEFICIARY)

(HIC NUMBER)

I request payment of authorized Medicare benefits be made either to me or on my behalf to **WEBSTER ORTHOPAEDIC MEDICAL GROUP** for any services furnished me by that physician/supplier. I authorize any holder of medical information about me to release to the Health Care Financing administration and its agents any information needed to determine these benefits payable to related services.

I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If item 9 of the HCFA-1500 claim form is completed, my signature authorizes releasing of the information to the insurer or agency shown. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance, and noncovered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier.

BENEFICIARY SIGNATURE

DATE

MEDICARE PATIENTS ONLY

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(NAME OF BENEFICIARY)

(HIC NUMBER)

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DATE