PREMIER ORTHOPEDICS, PC

ID#_____

Premier Doctor/Provider You Are Seeing Today: _____ Today's Date: _____

Name of Doctor who referred you here: _____ City & State: _____

Who is your Primary Care Physician: _____ City & State: _____

PATIENT INFORMATION

Full Name: _____ (First) _____ (Middle Initial) _____ (Last)

Address: _____

City: _____ State: _____ Zip: _____

Date of Birth: _____/_____/_____ Age: _____ Gender: ☐ Male ☐ Female

Social Security #: _____ Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Race: ☐ Caucasian ☐ Black/African American ☐ Hispanic ☐ Other_____ Language: ☐ English ☐ Spanish ☐ Other _____

Cell Phone: _____ Home Phone: _____ Work Phone: _____

Email: _____

I hereby request that Premier Orthopedics make all communications to me by the means that I have listed above. Please intial: _____

Employer: _____ Occupation:_____

Emergency Contact Name: _____ Emergency Phone: _____

TYPE OF INSURANCE

( ) COMMERCIAL ( ) MEDICARE ( ) MEDICAID ( ) WORKERS COMPENSATION ( ) AUTO ( ) NONE

WE WILL BE GLAD TO FILE YOUR INSURANCE FOR YOU.

☐ **INSURANCE SPONSOR IS SAME AS PATIENT.** ☐ **IF THE INSURANCE SPONSOR IS DIFFERENT, COMPLETE THIS SECTION:**

PRIMARY INSURANCE: _____ Sponsor's Name:_____

Insured Sponsor's Date of Birth: _____/_____/_____ Social Security #: _____

SECONDARY INSURANCE (If Applicable):_____ Sponsor's Name:_____

Insured Sponsor's Date of Birth: _____/_____/_____ Social Security #: _____

IF RESPONSIBLE PARTY IS OTHER THAN PATIENT, PLEASE COMPLETE (MUST BE PERSON SIGNING THIS FORM)

Responsible Party Name: _____ Date of Birth: _____

Responsible Party Social Security Number: _____Relationship to Patient:_____

Responsible Party Address: _____

City_____State: _____Zip: _____Phone:_____

Employer: _____ City_____ State_____Zip_____

PLEASE READ THE FOLLOWING AND SIGN BELOW

All professional fees are due at the time of service. I hereby authorize Premier Orthopedics, PC to release information concerning my illness and treatments to insurance companies, attorneys, other physicians, and/or other specific interested parties. I hereby assign to the physicians all payments for medical services for my dependents or myself. I understand that I am responsible for any balance not paid by my insurance or third party. Patient does hereby consent to the rendering of medical care and treatment, which may include diagnostic testing procedures and such treatment and care as considered necessary or appropriate by the rendering physician. Further if I do not give 24 hour notice prior to cancellation of an appointment, a "no show" fee of $35.00 will be billed to my account and is my responsibility.

Signature of Patient _____ Date: _____

Signature of Responsible Party: _____ Date:_____ Rev. 7/2018