

PATIENT INFORMATION FOR MEDICAL RECORDS

NAME _____ FEMALE MALE
HOME ADDRESS _____
CITY _____ STATE _____ ZIP _____
MAILING ADDRESS _____
HOME PHONE (_____) _____ - _____ CELL NUMBER (_____) _____ - _____
SOCIAL SECURITY NO. _____ - _____ - _____ MARITAL STATUS S M W D
BIRTHDATE ____ / ____ / ____ AGE _____ WT. _____ HT. _____ DRV. LIC. _____
EMPLOYED BY _____ WORK PHONE (_____) _____ - _____
WORK ADDRESS _____ OCCUPATION _____
DATE OF INJURY ____ / ____ / ____ **ALLERGIES TO MEDICATIONS?** _____
WHO REFERRED YOU TO THIS OFFICE? FRIEND SELF PHYSICIAN _____

PRIMARY CARE PHYSICIAN

NAME _____ PHONE (_____) _____ - _____

IF PATIENT IS A MINOR, PLEASE COMPLETE THIS SECTION

DIVORCED OR SEPARATED PARENTS: IT IS OUR OFFICE POLICY THAT THE PARENT ACCOMPANYING THE CHILD FOR TREATMENT WILL BE HELD RESPONSIBLE FOR ALL BILLS. WE CANNOT BILL THE OTHER PARENT.

NAME OF RESPONSIBLE PARTY _____ DRV. LIC. _____
MAILING ADDRESS _____ STATE _____ ZIP _____
HOME PHONE (_____) _____ - _____ WORK PHONE (_____) _____ - _____
RELATIONSHIP TO PATIENT _____ SOC. SEC. NUM. _____ - _____ - _____
EMPLOYED BY _____ OCCUPATION _____

PERSON TO CONTACT IN CASE OF EMERGENCY

NAME _____ RELATIONSHIP _____ PHONE (_____) _____ - _____

MEDICAL INSURANCE INFORMATION

HOW DO YOU INTEND TO PAY? CASH CHECK CREDIT CARD
INSURANCE WORK INJURY

INSURANCE INFORMATION

NAME OF POLICY HOLDER _____ RELATIONSHIP _____
NAME OF INSURANCE COMPANY _____ ID NUMBER _____
GROUP _____ POLICY HOLDER'S BIRTHDATE ____ / ____ / ____

IF YOUR INJURY IS JOB RELATED

NAME OF EMPLOYER AT TIME OF INJURY _____
NAME OF PERSON WHO CAN AUTHORIZE TREATMENT _____

I ASSIGN AND REQUEST PAYMENT OF MEDICAL BENEFITS TO FOLSOM ORTHOPAEDIC SURGERY & SPORTS INJURY MEDICAL CLINIC, INC. FOR SERVICES RENDERED. I HEREBY AUTHORIZE SAID ASSIGNEE TO FURNISH INFORMATION NECESSARY TO PROCESS MY CLAIM AND TO FORWARD MEDICAL RECORDS FOR CONTINUATION OF MEDICAL CARE. I UNDERSTAND I AM FINANCIALLY RESPONSIBLE FOR ANY UNPAID BALANCE WITHIN 30 DAYS OF MY VISIT. A PHOTOCOPY OF THIS AUTHORIZATION SHALL BE AS VALID AS THE ORIGINAL.

DATE ____ / ____ / ____ SIGNATURE _____