PATIENT DEMOGRAPHICS	FOLSOM ORTHOPAEDIC SURGERY		
First Name	MI	Last Name	
Address			
City	ST	ZIP	
DOB / /	Marital Status S☐ M☐ D☐ W☐	Sex ☐M ☐F	SS
Primary Phone to reach you ( )		Other Number ( )	
Employer	Occupation		
May we leave information on your voice mail/machine? Yes ☐ No☐			
Who Referred you? Physician ☐ Family ☐ Friend ☐ Insurance ☐ Other			
Referring Physician's Name			
In the event of an emergency please contact			
Name	Relationship	Phone ( )	
Minor Patients Name of Parent/Guardian			
Address if different from above			
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.			
Insurance Information			
Primary Insurance	Policy Holder Name		
Relationship to Insured Self☐ Spouse☐ Child☐ Other	Insured's DOB		
ID#	Group#		
Secondary Insurance	Policy Holder Name		
Relationship to Insured Self ☐ Spouse ☐ Child ☐ Other	Insured's DOB		
ID#	Group#		
IF YOUR INJURY IS JOB RELATED OR A PERSONAL INJURY, PLEASE SEE STAFF IMMEDIATELY			

NOTICE REGARDING INSURANCE CLAIMS/PAYMENTS:

If we are filing an insurance claim for your visit, we must have complete information and any required referral at the time of the visit. If you cannot provide the information, we will be unable to file your claim and payment in full will be required.

Payment of your charges cannot be determined until the claim is submitted to your insurance company. Payment will be based on your health plan and the amount applied to you plan deductible and/or coinsurance will be your responsibility. Procedures which are excluded from coverage based on your plan's determination of medical necessity will also be your responsibility. Your office visit co-pay is due at the time of the visit. If you have a deducible plan, we will collect a deposit towards your visit.

I assign and request payment of medical and surgical 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 that 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:_____