

PATIENT DATA**YOU MUST COMPLETE ALL INFORMATION REQUESTED**

Date: \_\_\_\_\_

M  F 

PATIENT'S NAME: \_\_\_\_\_ Age: \_\_\_\_\_ DOB: \_\_\_\_\_

Address: \_\_\_\_\_

Telephone: (\_\_\_\_) \_\_\_\_\_ Street \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Email: \_\_\_\_\_

Work telephone: \_\_\_\_\_ SS# \_\_\_\_\_ Preferred Language: \_\_\_\_\_

Race: \_\_\_\_\_ Ethnicity \_\_\_\_\_ I decline to state  (check here)

Preferred Pharmacy Address: \_\_\_\_\_ Phone #: \_\_\_\_\_

Name of Referring Physician \_\_\_\_\_ Phone No. \_\_\_\_\_  
(first & last name)

Referring Physicians' Address: \_\_\_\_\_

Emergency Contact Name/Relationship &amp; Phone: \_\_\_\_\_

Name of Spouse \_\_\_\_\_ Home Telephone: \_\_\_\_\_

SS# \_\_\_\_\_ Work Phone: \_\_\_\_\_

If Minor, Parents Name: \_\_\_\_\_ Telephone: \_\_\_\_\_

 I am not covered by insurance and I understand that payment is due at the time that services are rendered.**Primary Insurance:** \_\_\_\_\_ **Subscriber's Name/Date of Birth:** \_\_\_\_\_

(If other than self)

ID No. \_\_\_\_\_ Group No.: \_\_\_\_\_

**Secondary Insurance:** \_\_\_\_\_ ID No. \_\_\_\_\_Is this a work injury? Yes  No  If Yes: Claim No: \_\_\_\_\_ Date of Injury: \_\_\_\_\_

Employer: \_\_\_\_\_ Employer Phone: \_\_\_\_\_

Worker's Comp Insurance Carrier: \_\_\_\_\_ Adjuster: \_\_\_\_\_

Address of Carrier: \_\_\_\_\_

Adjuster's Phone No.: \_\_\_\_\_ Fax No.: \_\_\_\_\_

Employer at time of injury: \_\_\_\_\_ Phone: \_\_\_\_\_

**AUTHORIZATION FOR TREATMENT. BILLING INSURANCE INSTRUCTIONS: PATIENTS COVERED BY INSURANCE ON PLANS WHICH ARE NOT ACCEPTED ARE RESPONSIBLE FOR PAYMENT AT THE TIME THAT SERVICES ARE RENDERED.** I authorize treatment of the person named above and agree to pay all fees and charges for such treatment. I hereby authorize the Santa Cruz Orthopaedic Institute to furnish information to insurance carriers concerning this illness/accident and hereby irrevocably assign to the doctor all payments for medical services rendered. **I understand that I am financially responsible for all charges whether or not covered by insurance.** ALL PATIENTS OR PATIENT REPRESENTATIVE IF MINOR, MUST SIGN BELOW. MEDICARE PATIENTS MUST **SIGN BOTH AREAS.** THANK YOU.

SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_

***For our patients with MediCare:***

I request that payment of authorized MediCare benefits be made on my behalf to Santa Cruz Orthopaedic Institute for any services furnished me by that physician. 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 authorize release of medical information necessary to pay the claim. If other health insurance coverage is indicated in Item 9 of the HCFA-1500 claim form or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes releasing of the information to the insurer or agency shown. This is in effect for my lifetime unless revoked in writing.

SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_