

Name:
Chart:
Date:



Patient _____ Social Security # _____
Last First Middle

Address _____ City _____ State _____ Zip Code _____

Birthdate _____ Age _____ Sex: _____ Marital Status: M D W S Child

Home Phone _____ Work Phone _____ Referred by _____

Employer of Patient or Parent _____ Address _____ Phone _____
(Circle One)

Occupation of Patient _____

Name of Spouse or Parent _____ Phone _____
(Circle One)

Address, if different from patient _____

Employer of Spouse or Other Parent _____ Address _____ Work Phone _____
(Circle One)

Is Patient Allergic to any Medication? _____ If yes, please list _____

IN CASE OF EMERGENCY: Name & Address of relative/friend not living in the home _____

_____ Relationship _____ Phone No. _____

If the patient is a **minor**, please list: Father's birthdate _____ Mother's birthdate _____

Father's SS # _____ Mother's SS # _____

Insurance: 1) _____ Group No. _____ ID # _____

2) _____ Group No. _____ ID # _____

Medicare _____ / _____ / _____ Is this workman's compensation? _____ Authorized? Yes No

Do you have an attorney, if so, who? _____

Is another insurance company, other than your health insurance responsible for your bills? _____

What company _____ Adjuster's Name _____ Phone No. _____

Insured _____ Adjuster's Name _____ Phone No. _____

I hereby authorize payment directly to River City Orthopaedic Surgeons, P.S.C. for surgical and/or medical benefits, if any otherwise payable to me under the terms of my insurance.

I hereby authorize River City Orthopaedic Surgeons, P.S.C. to release any information acquired in the course of my examination or treatment.

I hereby authorize any physician, hospital or medical care facility to provide all information on my medical history & treatment to River City Orthopaedic Surgeons, P.S.C.

I acknowledge & understand that I am responsible for all of the charges for all of the services rendered to me or any member of my family. If my insurance requires a referral, I understand it is my responsibility to obtain this, or I will be responsible for the denied charges.

Although I have requested the doctor to bill my insurance company on my behalf, I clearly understand that it is my responsibility to make sure the bill is paid in a responsible time. If for any reason any portion of my bill is not paid by my insurance, I agree to make arrangements for prompt payment of the bill.

Signature of Patient or Parent, if Minor _____

Date _____