Orthopaedic Associates Surgery Center, LLC

PLEASE PRINT

DATE_____ PHYSICIAN _____

PATIENT'S FULL NAME _____

MAILING ADDRESS _____CITY_____STATE_____ ZIP CODE_____

HOME PHONE (_____)_____CELL PHONE (_____)_____PAGER #_____

DATE OF BIRTH _____AGE_____SOCIAL SECURITY #_____

MALE ☐ FEMALE ☐ MARRIED ☐ SINGLE ☐ DIVORCED ☐ WIDOWED ☐_____

ETHNIC ORIGIN: CAUCASIAN/WHITE ☐ BLACK/AFRICAN AMERICAN ☐ HISPANIC/LATINO ☐ ASIAN ☐ MULTI RACIAL ☐
AMERICAN INDIAN/ALASKA NATIVE ☐ NATIVE HAWAIIAN/OTHER PACIFIC ISLANDER ☐

EMPLOYER_____OCCUPATION _____

EMPLOYER'S ADDRESS_____

MAY WE CONTACT YOU AT WORK? YES ☐ NO ☐ IF YES, WORK PHONE (_____)_____

EMERGENCY CONTACT NAME: _____**PHONE #** (_____)_____

BILLING STATEMENTS WILL BE MAILED TO PATIENT'S ADDRESS

RESPONSIBLE PARTY NAME _____RESPONSIBLE PARTY S S #_____

RESPONSIBLE PARTY EMPLOYER _____WORK PH #_____

PRIMARY COMPLAINT/INJURY (specify right or left if appl.): _____

WORKER'S COMP ☐ AUTO ACCIDENT ☐ DATE OF ACCIDENT OR ONSET OF SYMPTOMS _____

HOW AND WHERE DID INJURY OCCUR?_____

PRIMARY INSURANCE

NAME OF INSURANCE _____NAME OF INSURED_____

POLICY # _____INSURED'S DATE OF BIRTH_____

GROUP #_____RELATIONSHIP TO PATIENT_____

MAIL CLAIM TO: _____

EMPLOYER NAME AND ADDRESS _____

SECONDARY INSURANCE

NAME OF INSURANCE _____NAME OF INSURED_____

POLICY # _____INSURED'S DATE OF BIRTH_____

GROUP #_____RELATIONSHIP TO PATIENT_____

MAIL CLAIM TO: _____

EMPLOYER NAME AND ADDRESS _____

WORKER'S COMPENSATION INFORMATION

MAIL CLAIM TO_____ PHONE #_____

_____VERIFIED BY: _____

"I consent to treatment/surgery and photos taken during surgery (if needed) and authorize Orthopaedic Associates Surgery Center, LLC, to release to any insurance company or government agency any and all information necessary to process this claim, and request that payment be made to the party who accepts assignment of this claim. I understand that charges not covered by my carrier are my responsibility. I permit a copy of this authorization to be used in place of the original."

SIGNATURE _____ **DATE** _____

FOR OFFICE USE: _____ID Checked _____ Demographics Checked: _____/_____/_____
INITIAL DATE TIME