Centers for Advanced Orthopaedics - Parkway Division

Patient Information Form

Patient Name _____ Birth Date _____ Soc. Sec. # _____

Mailing Address _____ City _____ State _____ Zip _____

Home Phone _____ Cell Phone _____ Sex _____

Email _____ PCP/Family Doctor _____

Marital Status S M D W Preferred Language: English Spanish French Other _____

Race: White Black Asian Native American Native Hawaiian Type Unknown Decline To Provide

Ethnicity: Hispanic Origin Non-Hispanic Origin Type Unknown Decline To Provide

Employed? Full Time Part Time Retired Not Employed Occupation _____

Employer _____ Phone Number _____

Spouse's Name _____ Birth Date _____ Soc. Sec. # _____

Spouse's Employer _____ Phone Number _____

If Under 18-Parent/Guardian/Responsible Party _____

Home Phone _____ Soc.Sec. # _____ Birth Date _____

Mailing Address (If Different From Patient's) _____

Emergency Contact _____ Daytime Phone _____ Relationship _____

Individual(s) We May Discuss/Release Information To On Your Behalf _____

Reason for Visit _____

Date of Onset _____ Place Injury Occurred _____

Check Here If you DO NOT have Insurance ❑ ***PLEASE GIVE THE RECEPTIONIST YOUR INSURANCE CARDS TO PHOTOCOPY**

Primary Insurance Company _____ Subscriber _____

Relationship _____ Birth Date _____ Employer _____

ID # _____ Group # _____ Do You Have A Co-Pay? Y N $ _____

Secondary Insurance Company _____ Subscriber _____

Relationship _____ Birth Date _____ Employer _____

ID # _____ Group # _____ Do You Have A Co-Pay? Y N $ _____

Can appointment reminders be left of your answering machine or voice mail? YES NO

I hereby authorize the Centers for Advanced Orthopaedics - Parkway Division, to apply for benefits on my behalf and/or my dependants for services rendered. I request that payment by my insurance company/companies be made directly to the Centers for Advanced Orthopaedics - Parkway Division.

I certify that the information I have reported with regard to my insurance coverage is correct. I authorize the release of any necessary information, including medical information for this or any related claim, to process my claims. I permit a copy of this authorization to be used in place of the original. Either my insurance company or I may revoke this authorization at any time in writing.

I agree to promptly pay all charges when billed for medical services rendered and accept legal responsibility for any and all charges for the patient named above.

X _____ _____ _____

Patient/Guardian/Responsible Party Relationship to Patient Date