

Name: _____ Date: _____

Home address: _____ City: _____

State: _____ Zip: _____ Phone #: _____ Cell #: _____

Birthdate: _____ Age: _____ SS# _____ Sex: M FMarital status: S M D W If married, spouse's name: _____

Spouse's SS#: _____ Spouse's birthdate: _____

Who is the policy holder? _____ Relationship: _____

Policy holder's date of birth: _____ Who referred you to our office? _____

Employer: _____ Work phone #: _____

Employer address: _____ City: _____ State: _____ Zip: _____

Emergency contact: _____ **Relationship:** _____ **Phone #:** _____**Did the injury happen at above workplace?** Yes No At home? Yes No Other: Yes No

Date of injury: _____ If Other, where? _____

Did the injury happen as a result of a motor vehicle accident? Yes NoDate of Accident: _____ Have you notified your auto insurance carrier? Yes No**Do you have an attorney who is representing you in either of the above cases?** Yes No

If yes, Name: _____ Phone #: _____

If patient is under the age of 18, name of parent/guardian accompanying patient to today's visit.

Name: _____ Relationship: _____

ANYONE UNDER THE AGE OF 18 MUST BE ACCOMPANIED BY AN ADULT IN ORDER TO RECEIVE TREATMENT FOR THEIR INJURIES OR WE WILL BE UNABLE TO TREAT THEM.

INSURANCE SUBMISSION: A copy of your insurance cards is required if you would like our office to submit for services rendered. Please remember that you are responsible for all deductible, co-pay and non-covered service amounts. See our complete financial policy for details.

A copy of our *HIPPA Privacy Policy* is posted in our waiting room and a copy is available upon request. Please take a moment and review this policy then sign below.

HIPPA Privacy Policy reviewed by: _____ Date: _____

I hereby authorize Easton Orthopaedic Group to submit a claim to my insurance company or its intermediaries for all services rendered. Any information needed by my insurance company to make payment directly to Easton Orthopaedic Group is also authorized.

Name of Patient/Responsible Party: _____ Date: _____

If Medicare patient:

Name of Medicare Beneficiary: _____ HIC#: _____