

This box is for filing purposes. Please print in color if possible.



### PATIENT INFORMATION

\_\_\_\_\_  
ACCOUNT #

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_____ Last Name	_____ First	_____ Middle	_____ Home Phone	_____ Work Phone
_____ Street or Route #	_____ City	_____ State	_____ Zip	_____ Birth Date
			_____ Soc. Sec. #	

### GUARANTOR INFORMATION (If different from patient)

Guarantor's Relationship to the Patient:  Self  Husband  Wife  Child  Other:\_\_\_\_\_

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_____ Last Name	_____ First	_____ Middle	_____ Home Phone	_____ Work Phone
_____ Street or Route #	_____ City	_____ State	_____ Zip	_____ Birth Date
			_____ Soc. Sec. #	

### OCCUPATION INFORMATION

Are you currently:  Unemployed  Homemaker  Working  Student  Other:\_\_\_\_\_

Patient or Guarantor Occupation: \_\_\_\_\_ Employer:\_\_\_\_\_

Employer's Address: \_\_\_\_\_

Street/Route #                      City                      State                      Zip Code

### EMERGENCY INFORMATION

Person to notify in case of emergency (Friend/Relative Not At Your Address): \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_ Phone: \_\_\_\_\_

Who do you want to be able to access your medical information: (please give name and phone number)

- Spouse \_\_\_\_\_
- Children \_\_\_\_\_
- Relative \_\_\_\_\_
- Friend \_\_\_\_\_
- Other \_\_\_\_\_

What is the best time for us to communicate with you? \_\_\_\_\_

May we leave messages for you on your Answering Machine?  Yes  No

### INSURANCE INFORMATION

**Note:** If you have Tricare of Medicare, and your spouse has insurance that covers you where they are employed, Champus, Tricare, and Medicare will be Secondary Coverage.

Do you have Health Insurance?  Yes  No

If "No", how do you plan to pay your account? \_\_\_\_\_

Primary Insurance Co. \_\_\_\_\_ Policy \_\_\_\_\_ Group \_\_\_\_\_

Subscriber's Name \_\_\_\_\_ Soc. Sec. # \_\_\_\_\_

Secondary Insurance Co. \_\_\_\_\_ Policy \_\_\_\_\_ Group \_\_\_\_\_

Subscriber's Name \_\_\_\_\_ Soc. Sec. # \_\_\_\_\_

Although we will need to make a photostatic copy of your insurance card(s) today, we do not know the benefit provisions of your policy. It is the patient/parent/guardian's responsibility to inform us if their insurance company requires pre-authorization and/or a second opinion BEFORE procedures are performed.

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**WORKER'S COMPENSATION INCIDENT**

Complete this section if your illness or injury resulted from an on-the-job incident.

Date of incident: \_\_\_\_\_ Have you reported the incident to your employer? \_\_\_\_\_

W.C. Claim File # \_\_\_\_\_ Phone # \_\_\_\_\_

How did incident occur? \_\_\_\_\_

Address: \_\_\_\_\_  
Street/Route # City State County

**AUTOMOBILE ACCIDENT**

Complete this section if injury was the result of a motor vehicle accident.

Date of accident: \_\_\_\_\_ Place of accident: \_\_\_\_\_  
City State County

Insurance Co.: \_\_\_\_\_ Name of Adjustor: \_\_\_\_\_

Insurance Address: \_\_\_\_\_  
Street City State

Insured's Name: \_\_\_\_\_ Policy #: \_\_\_\_\_

Claim #: \_\_\_\_\_ Insurance Phone: \_\_\_\_\_

**OTHER TYPE OF ACCIDENT**

Complete this section if accident will be filed under homeowner's or some other insurance.

Date of accident: \_\_\_\_\_ Place of accident: \_\_\_\_\_  
City State County

How accident occurred: \_\_\_\_\_

Name of Responsible Party: \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_  
Street/Route # City State County

Name of Insurance Co.: \_\_\_\_\_ Insured's Name: \_\_\_\_\_

Policy #: \_\_\_\_\_ Policy Holder's Name: \_\_\_\_\_

**REFERRAL INFORMATION**

Who may we thank for referring you to our office? \_\_\_\_\_

**REQUEST FOR TREATMENT& ASSIGNMENT OF INSURANCE BENEFITS**

I have requested the treatment provided by Elizabethtown Orthopaedic Associates and hereby authorize the release of any information relating to all claims for benefits submitted on their behalf. I hereby authorize my insurance company to pay any benefits, otherwise due me, if any, to Elizabethtown Orthopaedic Associates, P.S.C., for services. I understand that I am financially responsible for all charges not covered by insurance of contractual agreements and that any insurance benefits received by Elizabethtown Orthopaedic Associates, P.S.C. will be credited to my account.

Date Signed \_\_\_\_\_ Authorized Signature \_\_\_\_\_