Premier ORTHOPAEDICS

Name:_____ DOB:_____SS#_____ Today's Date: _____

Address:_____ Apt#_____

City:_____ State:_____ Zip:_____

Home Phone:_____ Cell Phone:_____

Work Phone:_____ E-Mail:_____

Race:_____ Ethnicity:_____ Gender: _____Preferred Language:_____

Primary Care Physician: _____ Referring Physician: _____

Primary Care Physician Address: _____

How did you hear about our practice? _____

Pharmacy Name and Phone: _____

Emergency Contact Name:_____ Emergency Contact Phone Number:_____

PLEASE GIVE ALL INSURANCE CARDS TO THE FRONT DESK

Primary Insurance

Type of Coverage: [ ] Health [ ] Workers Comp [ ] Auto Accident [ ] Slip & Fall

Date of Injury / Accident: _____If worker's comp, employment status: [ ] F/T [ ] P/T [ ] Self-employed

Employer's Name/Address/Zip/Phone: _____

_____

Insurance Company Name/Address/ Zip/Phone: _____

_____

Certification/I.D./Claim Number _____ Group Number: _____

Adjustor Name: _____ Adjustor Phone # _____

Subscriber Name: _____ Patient's Relationship: [ ] Self [ ] Spouse [ ] Child [ ] Other

Subscriber Address: (if different than patient) _____

Subscriber S.S. # _____ Subscriber Date of Birth: _____

Secondary Insurance

Insurance Company Name/Address/Zip/Phone:_____

_____

Certification/I.D. Number: _____ Group Number: _____

Subscriber: _____ Patient's Relationship: [ ] Self [ ] Spouse [ ] Child [ ] Other

Subscriber S.S. # _____ Subscriber's Date of Birth: _____

Is patient responsible for bills? _____YES _____NO If **NO**, please provide the following:

Name of Guarantor: _____ Date of Birth: _____

Address: _____

City, State, Zip Code: _____ Social Security #: _____

Relationship to patient: _____ Phone #: _____

Date:_____Signature of Patient, Parent or Guardian: _____