

# Inland Orthopaedic Surgery & Sports Medicine Clinic

## PATIENT INFORMATION

Please complete and bring with you to your appointment

DATE \_\_\_\_\_

Patient Name \_\_\_\_\_ Social Security # \_\_\_\_\_

Gender:  M  F Marital Status:  S  M Age \_\_\_\_\_ Birthdate \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ ST \_\_\_\_\_ Zip \_\_\_\_\_

Phone Number \_\_\_\_\_ Work/Message Phone \_\_\_\_\_

Employer's Name/Address \_\_\_\_\_ Occupation \_\_\_\_\_

Spouse's Name \_\_\_\_\_ Spouse's Employer \_\_\_\_\_

Spouse's Social Security # \_\_\_\_\_ Spouse's Birthdate \_\_\_\_\_

..... **STUDENTS/MINORS** .....

Parent's Address \_\_\_\_\_

City \_\_\_\_\_ ST \_\_\_\_\_ Zip \_\_\_\_\_ Phone \_\_\_\_\_

Father's Name \_\_\_\_\_ Mother's Name \_\_\_\_\_

Social Security # \_\_\_\_\_ Social Security # \_\_\_\_\_

Employer's Name \_\_\_\_\_ Employer's Name \_\_\_\_\_

Phone Number \_\_\_\_\_ Phone Number \_\_\_\_\_

Date of Birth \_\_\_\_\_ Date of Birth \_\_\_\_\_

..... **INSURANCE INFORMATION** .....

(Please provide us with photocopies of your insurance cards)

PRIMARY INSURANCE FOR THIS VISIT \_\_\_\_\_

Mailing Address \_\_\_\_\_ City \_\_\_\_\_ St \_\_\_\_\_ Zip \_\_\_\_\_

Claim Phone Number \_\_\_\_\_ Subscriber's Date of Birth \_\_\_\_\_

SUBSCRIBER'S NAME \_\_\_\_\_

ID# / Claim Number \_\_\_\_\_

.....

SECOND/OTHER INSURANCE NAME \_\_\_\_\_

Mailing Address \_\_\_\_\_ City \_\_\_\_\_ St \_\_\_\_\_ Zip \_\_\_\_\_

Claim Phone Number \_\_\_\_\_ Subscriber's Date of Birth \_\_\_\_\_

SUBSCRIBER'S NAME \_\_\_\_\_

ID# / Claim Number \_\_\_\_\_

Did a physician refer you to the clinic? If yes, please state whom: \_\_\_\_\_

Are you seeing the doctor today because of an accidental injury?  YES  NO

Please check type of accident/injury:  Work  Auto  Other Third Party

If accident occurred at work, who was employer? \_\_\_\_\_

Please briefly describe how accidental injury happened: \_\_\_\_\_

Date of Injury: \_\_\_\_\_ Date of Re-injury: \_\_\_\_\_

If injury is work-related, have you contacted your supervisor?  YES  NO

Have you filled out any necessary accident/injury reports?  YES  NO



**PLEASE READ**

If my insurance requires a referral from my primary care physician, I understand it is my responsibility to contact my physician for a referral to the orthopaedic specialist I have chosen to see, prior to my visit. I will assume responsibility for, and payment of, any balances due should any services be denied for lack of referral from my primary care physician.

I understand it is my responsibility to pay any deductible amount, co-insurance, or any other balance not paid for by my insurance.

NOTE: Insurance is considered a method of reimbursing the patient for fees paid to the doctor, and is not a substitute for payment. Some insurance companies pay fixed allowances for certain procedures, and others pay a percentage of the charge. If you are unsure about your coverage, please check your policy.

To the extent necessary to determine liability for payment, and to obtain reimbursement, I authorize disclosure of portions of the patient's record acquired in the course of the examination or treatment.

I hereby assign all medical and/or surgical benefits related to treatment from Inland Orthopaedics including Medicare, private insurance and other health care plans to: Inland Orthopaedic Surgery & Sports Medicine Clinic.

SIGNED \_\_\_\_\_ DATE \_\_\_\_\_

IF PATIENT IS UNABLE TO SIGN, RELATIONSHIP TO PATIENT \_\_\_\_\_  
(Parent, legal guardian)

This assignment of benefits will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand I am financially responsible for all charges whether or not paid by said insurance.

**—THANK YOU—  
FOR FILLING OUT IN FULL!**