

THE BONE & JOINT CLINIC



PATIENT'S NAME: (no nick name)

(First) _____ (Middle) _____ (Last) _____

ADDRESS: _____

_____ PATIENT'S SEX: Male Female

DATE OF BIRTH: _____ AGE: _____ MARITAL STATUS: M S W D

HOME PH: _____ CELL PH: _____ PATIENT'S SS#: _____

REFERRED TO CLINIC BY: DR _____, Newspaper _____, TV _____, Friend _____,
Yellow Pages _____, or Other _____

NAME OF INSURANCE: _____

SECONDARY INSURANCE: _____

INSURANCE IN NAME OF: _____ DATE OF BIRTH: _____

INSURANCE ID#: _____ GROUP #: _____

NEXT OF KIN NOT LIVING WITH YOU:

Name: _____ Phone: _____

PATIENT'S EMPLOYER: (If Minor, Father's Name) _____

Employer: _____ Phone: _____

Address: _____ SS#: _____

SPOUSE'S NAME: (Put Mother's Name & Information if Patient is Minor)

Name: _____ Employer: _____

Employer's Address: _____

Phone: _____ SS#: _____

WERE YOU HURT AT WORK? _____ PART OF BODY TO BE TREATED: _____

HOW WERE YOU INJURED & DATE OF ACCIDENT? _____

ALLERGIC TO: _____

ARE YOU A DIABETIC OR HAVE ANY OTHER SERIOUS HEALTH PROBLEMS? _____

I AUTHORIZE RELEASE OF MEDICAL INFORMATION TO THE ABOVE INSURANCE COMPANY.

DATE & SIGN: _____

I UNDERSTAND I AM RESPONSIBLE FOR THIS ACCOUNT AND THAT PAYMENT IS DUE AT THE TIME OF THE VISIT.

DATE & SIGN: _____