Welcome to Inland Orthopaedics!
Help us do our job better by completing this form accurately. Thank you

# PATIENT INFORMATION

-- please print --

Office Use

Account #________________________

Doctor: ________________________

_______ _______ _______

_______ _______ _______

MEDICAL INFORMATION INSURANCE INFORMATION PATIENT

Patient Legal Name: ________________ (Last name) ______________ (first name) ____ (m.initial) Soc. Security:_____-____-________

Patient Address: ____________________________ City: ____________ State: _____ Zip: _______

Home Phone: ____________ Cellular Phone:____________

Patient birthdate: ____________ Age: ____ Sex: ❑M ❑F Marital Status: ❑Single ❑Married ❑Widowed ❑Divorced

**If Minor Parents Name**________________________________________

**Patient Employed at:**__________________________ Work phone:_________________ ❑ okay to call wk

Employer's Address______________________ **City**_______________ **State**______ **Zip**__________

Primary Insurance Company: ________________________________________________

Subscriber's Name________________ (Last name) ______________ (first name) ______ ( (initial) Date of Birth______________

Insurance Co Address: ______________________ City: ______________ State: _____ Zip: ________

Insurance Company Phone: ________________

Subscriber Policy Number: ______________________ (May be Soc Sec Number) Group: _________________

Secondary Insurance Company: (if any)________________________________________

Subscriber's Name________________ (Last name) ______________ (first name) ______ (initial) Date of Birth______________

Insurance Co. Address: ______________________ City: ______________ State: _____ Zip: ________

Insurance Company Phone: __________________

Area on body to be examined: ____________________________ Which Side? ❑Right ❑Left

Date of Injury/Onset of problem: (If possible be specific) Month ______ Day_____ Year______

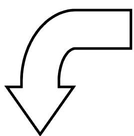
If injury indicate where it took place: ❑Home ❑School ❑Sports ❑Auto ❑Work ❑Motorcycle

Referring Doctor: Dr. ____________ (first name) ______________ (Last name) Telephone: _______________________

Family Doctor: Dr. ____________ (first name) ______________ (Last name) Telephone: _______________________

Emergency contact and phone: ____________________________________( **Must be # other than home**)

Have you or any family member been seen in this office before? ❑Yes ❑No By whom: __________________



**Please continue on reverse side!**

PTINFO.PUB 1/01/2008

## Credit and Payment Policy

*Our credit policy is outlined below. The bookkeeping department is here to assist you in any way we can either in person or over the phone for any questions or concerns that you have regarding your insurance. The rules that determine the specific benefits provided by one's medical insurance vary depending upon one's individual contract. We encourage you to familiarize yourself with the rules that apply to your contract.*

**Medicare patients:** Please bring your Medicare card and your supplemental insurance information. If you have a Medicare Replacement Policy please provide that card instead of the Medicare card. We accept assignment for Medicare and Medicare Replacement coverage and will bill your supplemental insurance provided we have the information we need. You will be billed for any remaining balance after your insurance plans have processed the charges.

**HMO/Managed Care Plans:** It is your responsibility to make sure a current referral has been obtained for your care with our office. If no referral has been obtained, your appointment may need to be rescheduled until you have a current referral.

**Co-pays:** Your co-pays must be paid at the time of each visit. If the co-pay is not paid at the time of the service, there will be a $10 billing fee charged.

**Commercial or indemnity plans:** We need a copy of your current insurance card to bill for your visit. It is your responsibility to verify if we are contracted with your insurance carrier. Benefits may vary if we are out of network. Please ask our billing department if you have any questions or need assistance.

**Workers Compensation:** Please bring your claim number, date of injury and mailing address of where we are to bill. We also need to know if you have any additional private insurance coverage. Please bring this insurance card with you to your appointment.

**Public Assistance:** You need to bring your current coupon with you to each visit.

**Motor Vehicle:** We will bill your own car insurance company for you if you have PIP coverage. We will need to know if you have medical insurance in the event that the PIP is exhausted. It is our policy not to wait for settlement for payment of your services.

I, the undersigned, acknowledge that I have read the policy and that I agree to the policy therein. I authorize payment of medical benefits directly to Dr. ___________________ for any services furnished to me by the physician. I understand that I am financially responsible for any amount not covered by my contract. I also authorize you to release to my insurance company information concerning health care, advice, treatment or supplies provided to me. This information will be used for the purpose of evaluating and administering claims of benefits.

**Date:** ________________ **Signed:** ______________________________________________________