PATIENT INFORMATION SHEET

(Please fill in ALL requested information)

Patient's Name: _____ *Sex: M F*

DOB: _____ *SS#:*_____ *Marital Status: Single Married*

*Home Phone:*_____ *Cell:*_____ *Email:*_____

*Home Address:*_____ *City/State*_____ *Zip Code:*_____

*Mailing Address:*_____ *City/State*_____ *Zip Code:*_____

*Primary Care Physician:*_____ *Referred By:*_____

Have you been a patient at Windward Orthopaedics before? ***Y N PERSON RESPONSIBLE FOR PAYMENT:***_____

EMPLOYMENT INFORMATION

(Do not complete if patient is a minor)

*Employer:*_____ *Occupation:*_____*Work #:*_____

*Address:*_____ *City/State:*_____ *Zip Code:*_____

INSURANCE INFORMATION

*Primary Insurance:*_____ *Policy No:*_____ *Coverage/Plan Code*_____

*Subscriber:*_____ *DOB:*_____ *SS#*_____*Relationship to patient*_____

*Secondary Insurance:*_____ *Policy No:*_____ *Coverage/Plan Code*_____

*Subscriber:*_____ *DOB:*_____ *SS#*_____ *Relationship to patient*_____

IF PATIENT IS A MINOR

(Please complete both father & mother information)

*Father's Name:*_____ *Mother's Name:*_____

*DOB:*_____ *SS#:*_____ *DOB:*_____ *SS#:*_____

Home#: _____ *Cell #:*_____ *Home#:* _____ *Cell #:*_____

*Employer:*_____ *Employer:*_____

*Occupation*_____ *Work#:*_____ *Occupation*_____ *Work#:*_____

*Employer Address:*_____ *Employer Address:*_____

*City/State:*_____ *ZipCode:*_____ *City/State:*_____ *ZipCode:*_____

IN CASE OF EMERGENCY

*Contact:*_____ *Work Phone:*_____ *Home Phone:*_____

*Cell:*_____ *Relationship to patient:*_____

Agreement:
I understand that the insurance carrier may require information regarding treatment in order to evaluate and administer claims and I authorize release of such information as necessary. I authorize the insurance carrier to pay the provider directly for services rendered. I agree to be ultimately responsible for payment of services rendered, and in the event that my account becomes delinquent, I agree to be responsible for any collection costs incurred.

Signature:_____ ***Date:*** _____