SOUTH ARKANSAS ORTHOPAEDICS AND SPORTS MEDICINE CLINIC

NEW PATIENT DEMOGRAPHIC/INSURANCE INFORMATION FORM

PATIENT NAME: _____ DOB _____ SS# _____

MAILING ADDRESS: _____

CITY_____ STATE_____ ZIP _____

HOME PHONE# _____ CELL PHONE# _____

EMERGENCY CONTACT: _____ PHONE# _____

E-MAIL ADDRESS: _____ DRIVERS LICENSE# _____

EMPLOYER: _____ EMPLOYER PHONE# _____

MARRIED____ SINGLE____ WIDOWED____ DIVORCED____ SEPERATED____ SEX: M_____ F_____

PHARMACY: _____ PHONE# _____

PRIMARY CARE PHYSICIAN: _____PHONE# _____

REFERRING PHYSICIAN:_____ PHONE#_____

WHAT ARE WE SEEING YOU FOR TODAY? _____

DATE OF INJURY_____ or ONSET OF SYMPTOMS_____

IF INJURED, WHERE AND WHEN DID YOUR INJURY TAKE PLACE?

_____

Please also list parent or guardian information here if the patient is a minor

PARENT NAME: _____ DOB _____ SS#_____

EMPLOYER: _____ PHONE#_____

PLEASE CIRCLE THE WAY YOU PREFER US TO CONTACT YOU

MAIL PHONE FAX EMAIL

RESPONSIBLE PARTY IF DIFFERENT FROM ABOVE: _____

RESPONSIBLE PARTY PHONE: _____ PHONE# _____

SOUTH ARKANSAS ORTHOPAEDICS AND SPORTS MEDICINE CLINIC

NEW PATIENT DEMOGRAPHIC/INSURANCE INFORMATION FORM

(MUST BE COMPLETED – SEE ATTACHED Not Acceptable)

PATIENT NAME _____ DOB _____

PRIMARY INSURANCE POLICY

NAME OF INSURANCE COMPANY _____
IDENTIFICATION OR POLICY # _____

POLICY HOLDER NAME _____ DOB _____
POLICY HOLDER SOCIAL SECURITY # _____ POLICY HOLDER SEX? MALE or FEMALE
POLICY HOLDER EMPLOYER _____
EMPLOYER ADDRESS _____ PHONE# _____

SECONDARY INSURANCE POLICY

NAME OF INSURANCE COMPANY _____
IDENTIFICATION OR POLICY # _____

POLICY HOLDER NAME _____ DOB _____
POLICY HOLDER SOCIAL SECURITY # _____ POLICY HOLDER SEX? MALE or FEMALE
POLICY HOLDER EMPLOYER _____
EMPLOYER ADDRESS _____ PHONE# _____

TO MY KNOWLEDGE ALL INFORMATION PROVIDED IS CORRECT AND I UNDERSTAND THAT FOR ALL CHARGES NOT COVERED BY INSURANCE OR ANY OTHER SOURCE INCLUDING COLLECTION FEES, I AM FINANCIALLY RESPONSIBLE TO SOUTH ARKANSAS ORTHOPAEDICS AND SPORTS MEDICINE CENTER. I HEREBY AUTHORIZE PAYMENT DIRECTLY TO SOUTH ARKANSAS ORTHOPAEDICS ALL BENEFITS DUE TO SERVICES FURNISHED BY THE AFOREMENTIONED. I AUTHORIZE SOUTH ARKANSAS ORTHOPAEDICS AND SPORTS MEDICINE CENTER TO RENDER MEDICAL TREATMENT ON MY BEHALF, AND AUTHORIZE THE RELEASE OF ALL MEDICAL RECORDS AND OTHER INFORMATION IN ORDER TO COLLECT ANY PAYMENT BALANCES. A PHOTOCOPY OF THIS ASSIGNMENT IS TO BE CONSIDERED AS VALID AS THE ORIGINAL. THIS ASSIGNMENT WILL REMAIN IN EFFECT UNTIL REVOKED BY ME IN WRITING.

X SIGNATURE OF PATIENT OR GUARDIAN _____ DATE _____