SOUTH ARKANSAS ORTHOPAEDICS AND SPORTS MEDICINE CLINIC

NEW PATIENT DEMOGRAPHIC/INSURANCE INFORMATION FORM

PATIENT NAME: _____ **DOB** _____ **SS#** _____

MAILING ADDRESS: _____

HOME PHONE# _____ **CELL PHONE#** _____

EMERGENCY CONTACT: _____ **PHONE#** _____

E-MAIL ADDRESS: _____ **DRIVERS LICENSE#** _____

EMPLOYER: _____ **EMPLOYER PHONE#** _____

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#** _____

PRIMARY PHYSICIAN: _____ **PHONE#** _____

REFERRING PHYSICIAN:_____ **PHONE#**_____

PHARMACY: _____ **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?

_____

SOUTH ARKANSAS ORTHOPAEDICS AND SPORTS MEDICINE CLINIC

NEW PATIENT DEMOGRAPHIC/INSURANCE INFORMATION FORM

PATIENT NAME _____ DOB _____

(MUST BE COMPLETED – SEE ATTACHED Not Acceptable)

INSURANCE INFORMATION

PRIMARY INSURANCE POLICY

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

NAME OF INSURANCE COMPANY _____
IDENTIFICATION OR POLICY # _____
POLICY EFFECTIVE DATE _____

SECONDARY INSURANCE POLICY

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

NAME OF INSURANCE COMPANY _____
IDENTIFICATION OR POLICY # _____
POLICY EFFECTIVE DATE _____

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 _____