PATIENT INFORMATION (please print) **DATE**__________________

Patient Name (first/middle/last)	Social Security #	Date of Birth / /	Age	Marital Status S M W D Sep	Male ☐ Female ☐
Address	City & State	Zip Code	Home Phone ( )		
Email Address			Cell Phone ( )		
Employer		Occupation			
Employer Address	City & State	Zip Code	Business Phone ( )		

All information required if insurance is listed with a spouse as the subscriber

Spouse's Name	Spouse's Social Security #		Spouse's Date of Birth / /	
Spouse's Employer	Address	City & State	Zip	Business Phone

If patient is a minor or student, please complete below:

Mother's Name	Mother's Social Security #		Mother's Date of Birth	
Mother's Employer	Address	City & State	Zip	Business Phone
Father's Name	Father's Social Security #		Father's Date of Birth	
Father's Employer	Address	City & State	Zip	Business Phone
If divorced or separated, spouse's address			Spouse's Phone	

If injured at school, name & address of school

Name of Family Doctor:	Name of Referring Doctor:

Emergency Contact:	Phone: ( )	Relationship:

PLEASE COMPLETE INSURANCE INFORMATION ON BACK SIDE ↺

When registering in our office, please present your insurance cards, any forms (completed and signed) and your referral if you have an HMO insurance.

HEALTH			
	Primary Insurance: Name & Address of Company		
	ID Number	Group Number	
	NAME OF SUBSCRIBER TO INSURANCE	*Subscriber's Social Security #*	*Subscriber's Date of Birth*
	Secondary Insurance: Name & Address of Company		
	ID Number	Group Number	
	NAME OF SUBSCRIBER TO INSURANCE	*Subscriber's Social Security #*	*Subscriber's Date of Birth*

WORK		
	WERE YOU INJURED ON THE JOB? **YES** ☐ **NO** ☐	IF YES, DATE OF INJURY________________
	If injured on the job, send bills to: Claim Number:	

AUTO		
	WAS AN AUTOMOBILE INVOLVED IN YOUR INJURY? **YES** ☐ **NO** ☐	IF YES, DATE OF INJURY ____________________
	Auto Insurance Information: (name & address of company) Claim Number:	POLICY NUMBER

LEGAL	
	Is a lawyer involved in your injury? **YES** ☐ **NO** ☐
	Name and Address of Attorney:

Please Read: All charges are payable at the time of service. If hospitalization is indicated, the patient is responsible for furnishing insurance claim forms to the office prior to hospitalization.

All professional services rendered are charged to the patient. Necessary forms will be completed to help expedite insurance carrier payments. However, the patient is responsible for all fees, regardless of insurance coverage. It is also customary to pay for services when rendered unless other arrangements have been made in advance with our Billing Department.

Insurance Authorization and Assignment

I hereby authorize Commonwealth Orthopaedic Associates to furnish information to insurance carriers concerning my illness and treatments and I hereby assign to the Physicians of Commonwealth Orthopaedic Associates all payments for medical services rendered to myself or my dependents. I understand that I am responsible for any amount not covered by insurance.

Date________________________________ **Signature**________________________________