ACCOUNT # ____________ DR. ____________ TIME IN ______

PATIENT INFORMATION

TIME OUT ______

PATIENT'S NAME (last, First, middle) ____________

SEX M / F DOB ______ SS# ______ MARITAL STATUS: S ☐ M ☐ WID ☐ DIV ☐ SEP ☐

STREET ADDRESS ____________ PHONE ( ) ______

CITY ______ ST. ______ ZIP ______ EMAIL ______

MAILING ADDRESS ____________

PATIENT OCCUPATION ______ EMPLOYER ______

EMPLOYER ADDRESS ______ PHONE ( ) ______ HOW LONG? ______

SPOUSE / PARENTS NAME ____________

INSURED PARENT NAME ____________

SEX M / F DOB ______ SS# ______ PHONE ( ) ______

STREET ADDRESS ____________

CITY ______ ST. ______ ZIP ______ EMAIL ______

OCCUPATION ______ EMPLOYER ______

EMPLOYER ADDRESS ______ PHONE ( ) ______ HOW LONG? ______

EMERGENCY CONTACT ______ PHONE ( ) ______

HOW DID YOU HEAR ABOUT US? ☐ DR. (NAME) ______ ☐ OTHER ______

☐ FAMILY / FRIEND ☐ EMPLOYER ☐ INSURANCE CO.

HAVE YOU OR ANY IMMEDIATE FAMILY MEMBER EVER BEEN TREATED BY OUR DOCTORS YES ☐ NO ☐

IF YES, PLEASE GIVE NAME ______ WHEN? ______

INSURANCE INFORMATION (PLEASE GIVE ALL INSURANCE CARDS TO RECEPTIONIST)

MEDICARE# ______ MEDICAL# ______

PRIMARY GROUP INSURANCE ______ ADDRESS ______

INSURED ______

GROUP# ______ CERTIFICATE# ______

DEDUCTIBLE ______ BENEFIT PLAN ______ CO-PAY ______

SECONDARY GROUP INSURANCE ______ ADDRESS ______

INSURED ______ CERTIFICATE# ______ EMPLOYER ______

IF BEING SEEN FOR INJURY, INDICATE DATE OF INJURY: ______

IF BEING SEEN FOR AUTO ACCIDENT, INDICATE DATE OF ACCIDENT ______

ATTORNEY THIS INJURY: NAME AND ADDRESS ______

TIME LOST FROM WORK DUE TO THIS INJURY ______ DATE LAST WORKED ______

Billing secondary insurance for HMO/PPO would allow you to receive maximum benefits where secondary insurance was indicated

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CONSENT FOR TREATMENT, AUTHORIZATION FOR RELEASE OF INFORMATION AND ASSIGNMENT OF INSURANCE BENEFITS.

ORTHOPAEDIC MEDICAL GROUP OF RIVERSIDE.

I hereby consent to and authorize all treatment considered necessary or advisable by the physician. I understand that various portions of my treatment may be provided by Physicians, Nurses or Physician's Assistants. I hereby consent to and authorize all treatment considered necessary or advisable by the Physician, Nurse or Physician's Assistant. I authorize payment directly to the above physician and hereby agree that I am financially responsible for any services rendered. Authorization to release any information needed for billing purposes shall remain valid for one year from this date unless revoked in writing.

SIGNED ____________ DATE ______

WORK RELATED INJURIES ONLY

DATE OF ACCIDENT ______ TIME OF DAY ______ DATE LAST WORKED ANYWHERE ______

APPROXIMATE TIME LOST FROM WORK DUE TO THIS INJURY ______

WHO WAS THE EMPLOYER AT TIME OF INJURY (COMPANY NAME) ______