

## PATIENT INFORMATION FORM

### PATIENT INFORMATION SECTION

|                                   |  |           |   |                         |  |     |
|-----------------------------------|--|-----------|---|-------------------------|--|-----|
| CIRCLE ONE<br>MR MRS MISS MS      |  | LAST NAME | FIRST NAME  | MAIDEN NAME             | BIRTHDATE / /  | AGE |
| STREET ADDRESS                    |  |           |   |                         | <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE                                  |     |
| CITY                              |  | STATE     | ZIP CODE  |                         | SOCIAL SECURITY NUMBER   |     |
| HOME PHONE                        |  |           | WORK PHONE  |                         | DRIVERS LICENSE NO.  |     |
| WHO REFERRED YOU TO OUR OFFICE?   |  |           | HAVE YOU BEEN TREATED BY ANY DOCTOR IN THIS PRACTICE BEFORE? <input type="checkbox"/> YES <input type="checkbox"/> NO   WHEN? |                         |  |     |
| NAME AND ADDRESS OF FAMILY DOCTOR |  |           |   |                         |  |     |
| EMPLOYER NAME                     |  |           |   | OCCUPATION              |  |     |
| EMPLOYER'S ADDRESS                |  | CITY      | STATE   | ZIP CODE                |  |     |
| SPOUSE OR PARENT'S NAME           |  |           | SOCIAL SECURITY NUMBER  | RELATIONSHIP TO PATIENT | <input type="checkbox"/> PARENT <input type="checkbox"/> SPOUSE <input type="checkbox"/> OTHER |     |
| ADDRESS OF SPOUSE IF DIFFERENT    |  | CITY      | STATE   | ZIP CODE                |  |     |

### EMERGENCY CONTACT

|      |              |            |            |
|------|--------------|------------|------------|
| NAME | RELATIONSHIP | HOME PHONE | WORK PHONE |
|------|--------------|------------|------------|

### INSURANCE INFORMATION - PLEASE PRESENT INSURANCE CARDS TO RECEPTIONIST

|                           |                       |      |                             |                       |  |
|---------------------------|-----------------------|------|-----------------------------|-----------------------|--|
| PRIMARY INSURANCE COMPANY |                       |      | SECONDARY INSURANCE COMPANY |                       |  |
| MAILING ADDRESS           |                       | CITY | STATE                       | MAILING ADDRESS       |  |
|                           |                       | CITY | STATE                       |                       |  |
| SUBSCRIBER                | RELATIONSHIP / D.O.B. |      | SUBSCRIBER                  | RELATIONSHIP / D.O.B. |  |
| I.D. NUMBER               | GROUP NUMBER          |      | I.D. NUMBER                 | GROUP NUMBER          |  |

### HISTORY OF PROBLEM

PLEASE EXPLAIN BRIEFLY WHY YOU ARE SEEING THE DOCTOR, SPECIFY LEFT OR RIGHT

FIRST SYMPTOM OR DATE OF INJURY

HOW DID INJURY OCCUR & WHEN?

|  |                  |                  |       |
|--|------------------|------------------|-------|
| WAS AN AUTOMOBILE INVOLVED? <input type="checkbox"/> YES <input type="checkbox"/> NO | DATE OF ACCIDENT | NAME OF ATTORNEY | PHONE |
|--|------------------|------------------|-------|

WERE YOU INJURED ON THE JOB?    YES    NO   *IF YES, COMPLETE WORK RELATED INJURIES SECTION.*

### WORK RELATED INJURIES

|  |  |      |                                |                       |  |
|--|--|------|--------------------------------|-----------------------|--|
| NAME OF COMPENSATION INSURANCE CARRIER |  |      | ADJUSTER'S NAME - PHONE NUMBER |                       |  |
| INSURANCE CARRIER ADDRESS              |  | CITY | STATE                          | ZIP CODE              |  |
| NAME OF EMPLOYER (AT TIME OF INJURY)   |  |      |                                | NAME OF SUPERVISOR    |  |
| ADDRESS                                |  |      |                                | SUPERVISORS PHONE NO. |  |
| NURSE CASE MANAGER                     |  |      |                                | PHONE                 |  |
| INDUSTRIAL CLAIM & CASE NO.            |  |      |                                | DATE OF INJURY        |  |

### RELEASE OF MEDICAL INFORMATION AND ASSIGNMENT OF BENEFITS

I hereby authorize WEBSTER ORTHOPAEDIC MEDICAL GROUP to release information regarding my treatment or examination rendered to me for medical or surgical care to insurance company(s) or its representatives. I also authorize payment to be made directly to WEBSTER ORTHOPAEDIC MEDICAL GROUP in the amount due for all medical and/or surgical charges for myself or my eligible dependents. I understand that I am financially responsible for any amounts not covered or paid by my insurance company(s).

SIGNATURE **X** \_\_\_\_\_ DATE \_\_\_\_\_

**OVER - PLEASE COMPLETE BACK OF FORM**

*To our medicare patients: Please sign Beneficiary Authorization on reverse side*