

EDMONDS ORTHOPEDIC CENTER

PATIENT INFORMATION

Name _____ Social Security # _____
Last First Middle

Birthdate _____ Age _____ Male Female Single Married Separated Divorced

Home Address _____
Street City State Zip

Home Phone _____ Cell Phone _____

Email Address _____ Employer _____ Occupation _____

Employer Address _____ Work Phone _____

Spouse / Parent Name _____ Work Phone _____

Spouse / Parent Employer _____

PRIMARY CARE PHYSICIAN: _____

REFERRED BY: _____

Reason for this visit: Illness Injury Other Job Related Injury* Auto Accident*

*Worker's Comp. Carrier / Auto Insurance _____ Claim # _____

Date of Injury or Onset of Problem _____ Part of Body Injured _____ Right Left Both

How did this happen? _____

If you were hospitalized for this: Where _____ When _____

PRIMARY Ins _____ SS # _____ Group # _____

Relationship to Subscriber

Subscriber _____ Subscriber's Date of Birth _____ Self Spouse Child

Employer _____ Address _____ Work Phone _____

SECONDARY Ins _____ SS # _____ Group # _____

Relationship to Subscriber

Subscriber _____ Subscriber's Date of Birth _____ Self Spouse Child

Employer _____ Address _____ Work Phone _____

In case of EMERGENCY: Relative to contact (other than spouse) _____ Phone _____

If someone other than the PATIENT is responsible for payment, complete the following:

Name of the responsible party _____ Address _____

Relationship to patient _____ Social Security # _____ Birthdate _____

I acknowledge that I am financially responsible for all charges. I hereby authorize my insurance benefits to be paid directly to my physician. I also authorize the doctor and / or insurance company to release any information required for this claim.

Note: If the patient is under 18 years of age, the accompanying parent is responsible for all bills.

Signature _____ Date _____