

DR _____ DATE _____ TIME _____ CHART # _____

PATIENT INFO	NAME - LAST		FIRST	MIDDLE	SS #	SEX	BIRTH DATE	AGE		
	STREET ADDRESS				HOME PHONE ()		WORK PHONE ()			
	CITY		STATE	ZIP CODE		CELL PHONE ()		EMAIL		
	EMPLOYER				MARITAL STATUS		STUDENT (CHECK ONE) <input type="checkbox"/> YES <input type="checkbox"/> NO		PREFERRED LANGUAGE	
	ADDRESS				FAMILY CONTACT NAME		CONTACT RELATIONSHIP			
	CITY		STATE	ZIP CODE		CONTACT CELL PHONE ()		CONTACT WORK PHONE ()		
	Race (check one - Gov't Required) <input type="checkbox"/> African American <input type="checkbox"/> Asian <input type="checkbox"/> Native American <input type="checkbox"/> Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other				Ethnicity (check one - Gov't Required) <input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Not Hispanic/Latino <input type="checkbox"/> Unknown					

GUARANTOR	NAME			EMPLOYER		
	ADDRESS			ADDRESS		
	CITY, STATE		ZIP CODE	CITY, STATE		ZIP CODE
	RELATION TO PATIENT	SOCIAL SECURITY NUMBER		WORK PHONE		HOME PHONE
	MUST COMPLETE: IN CASE OF EMERGENCY, NAME OF FRIEND OR RELATIVE NOT LIVING WITH YOU				PHONE	RELATIONSHIP

INSURANCE	INSURANCE (Please check one): <input type="checkbox"/> No Coverage <input type="checkbox"/> Auto Insurance <input type="checkbox"/> BCBS <input type="checkbox"/> CHAMPUS <input type="checkbox"/> HMO <input type="checkbox"/> Medicaid <input type="checkbox"/> Medicare <input type="checkbox"/> PPO <input type="checkbox"/> Workman's Comp. <input type="checkbox"/> Other					
	PRIMARY COMPANY			SECONDARY COMPANY		
	ADDRESS			ADDRESS		
	CITY, STATE		ZIP CODE	CITY, STATE		ZIP CODE
	SUBSCRIBER'S NAME		D.O.B.	SEX	SUBSCRIBER'S NAME	
	POLICY #		POLICY #			
	ID #	GROUP #		ID #	GROUP #	
SS #	RELATION TO PATIENT		SS #	RELATION TO PATIENT		

REFERRAL INFO	REFERRING PHYSICIAN - (CHECK BOX IF REFERRED THRU ER) <input type="checkbox"/> ER				CITY, STATE	
	X-RAYS <input type="checkbox"/> YES <input type="checkbox"/> NO	X-RAY TAKEN AT	X-RAY DATE	X-RAYS WITH PATIENT <input type="checkbox"/> YES <input type="checkbox"/> NO	FAMILY PHYSICIAN - CITY, STATE	
	ACCIDENT <input type="checkbox"/> YES <input type="checkbox"/> NO	ACCIDENT OCCURRED <input type="checkbox"/> WORK <input type="checkbox"/> HOME <input type="checkbox"/> AUTO <input type="checkbox"/> OTHER		ACCIDENT STATE	ACCIDENT DATE	DESCRIPTION OF ACCIDENT
	ATTY INVOLVED <input type="checkbox"/> YES <input type="checkbox"/> NO	IF YES, ATTORNEYS NAME AND PHONE NUMBER			BODY PART BEING TREATED	

SIGNATURES	RELEASE OF MEDICAL INFORMATION	
	AUTHORIZATION TO PAY BENEFITS TO PHYSICIAN: I hereby assign payment directly to Advanced Orthopaedic Associates, P.A., for the surgical and/or medical benefits, if any, otherwise payable to me for services as described, but not to exceed my indebtedness to Advanced Orthopaedic Associates, P.A., for those services.	
	INSURANCE INFORMATION RELEASE AUTHORIZATION: I hereby authorize Advanced Orthopaedic Associates, P.A., to release any information acquired in the course of my examination or treatment to my referring doctor and/or my insurance company or employer.	
	FINANCIAL AGREEMENT: I understand that I am responsible for all fees, regardless of insurance coverage. See separate Financial Policy/Agreement.	
	PATIENT'S SIGNATURE: _____	DATE _____
INSURED'S SIGNATURE (if other than patient) _____	DATE _____	