

PATIENT INFORMATION

Patient Name Birthdate Age
Mailing Address Home/Cell Phone
City/State/Zip Email (optional)
Soc. Sec # Marital Status Sex [] Male [] Female
Occupation Employer
Employer's Address Work Phone
Spouse's Name DOB Soc. Sec #
Employer Work Phone
In Case of Emergency Please Contact Phone
Referred by Phone
Drug Allergies

PARENT / GUARDIAN INFORMATION IF PATIENT IS A MINOR

Father/Guardian Name DOB Soc. Sec #
Address (if different from patient)
City State Zip Home Phone
Employer Phone
Mother/Guardian Name DOB Soc. Sec #
Address (if different from patient)
City State Zip Home Phone
Employer Phone

HEALTH INSURANCE (PLEASE PRESENT YOUR CARD TO RECEPTIONIST)

Primary Insurance Phone
Address City State Zip
Insured Name Soc. Sec # DOB
Policy ID # Group #
Secondary Insurance
Address City State Zip
Insured Name Soc. Sec # DOB
Policy ID # Group #

ACCIDENT INFORMATION (IF APPLICABLE)

Date of Accident Worker's Compensation [] or Auto Accident [] or Other []
Part of Body Injured Accident Happened in Which State
Insurance Carrier Phone
Address City State Zip
Claim or Policy # Name of Adjuster
Employer (if different from above) Phone

ASSIGNMENT AND RELEASE OF INFORMATION

NOTE: Insurance Pre-Authorization: It is the patient's responsibility to notify this office if your insurance carrier requires pre-authorization for any services. Assignment and Release of Information: I hereby authorize Missoula Bone & Joint to release any information acquired in the course of my examination and treatment to the insurance company. I also authorize payment directly to the physician. I understand that I am responsible for any amount not covered by insurance and that if my account is turned over for collections, the fee will be my responsibility. By signing below, I recognize and accept responsibility for any balance remaining after payment of benefits.

Signature of Responsible Party Relationship to Patient Date

CONSENT TO TREAT

I also hereby request and consent to treatment and services reasonable and proper by today's standards provided by a provider of Missoula Bone & Joint and any employee acting under my provider's orders.

Signature of Responsible Party Relationship to Patient Date