

KEMMLER ORTHOPAEDIC CENTER

Patient Legal Name _____
(Last) (First) (Middle)

Patient Address _____

City _____ State _____ Zip Code _____

Social Security # _____ Birthdate _____ Age _____ Marital Status _____

Home Ph.# _____ Work Ph.# _____ Cell Ph. # _____

Who referred you to our office? _____ Employer Name _____

Please send copy of records to family physician ___ No ___ Yes Physician Name _____

Person responsible for payment _____

(MUST BE PARENT OR GURADIAN) (Last) (First) (Middle)

Address _____ Home Ph.# _____

City _____ State _____ Zip Code _____

Social Security # _____ Birthdate _____ Age _____ Marital Status _____

Employer Name _____ Check here if retired _____

Employer Address _____ Phone # _____

City _____ State _____ Zip Code _____

WE WILL BE GLAD TO FILE YOUR INSURANCE FOR YOU BUT IT IS YOUR RESPONSIBILITY TO SEE THAT THIS BILL IS PAID. PAYMENT IS EXPECTED AT THE TIME OF SERVICE.

Please state the reason and area of the body you are here for today _____

Was this an injury? ___ Yes ___ No If yes, give date of injury _____ (be specific)

Work related? ___ Yes ___ No If yes, has claim been filed? _____ WC# _____

If you have Medicare, enter Medicare # _____

If you have Medicaid, enter Medicaid # _____

*Primary Insurance Co. _____

Policy # _____ SSN _____ Group # _____

Name of person holding insurance _____ Birthdate _____

Address/Ph # if different than above _____

Relationship of patient to insured _____

*Secondary Insurance Co. _____

Policy # _____ SSN _____ Group # _____

Name of person holding insurance _____ Birthdate _____

Address/Ph # if different from above _____

Relationship of patient to insured _____

Patient's authorization to release medical information and claim payment authorization:

I hereby authorize the above physician(s) to release any information regarding services rendered by him and allow a photo copy of my signature to be used for insurance purposes. I authorize the above information is correct and if any changes occur in names or addresses to let the office staff be aware. I also understand I am financially responsible for the fees for services rendered. I authorize payment of medical benefits to the undersigned physician or supplier for services below.

Date

Responsible Person/ Policy owner/ insured