2004

**WELCOME TO THE OFFICE OF**
**ORTHOPEDIC PROFESSIONAL ASSOCIATION**
(Please fill out completely, print and sign at the bottom)

## PATIENT INFORMATION

Name_____Today's Date: _____
Last First Middle

Permanent/Parent
Address_____
Street Apt. City State Zip

Local
Address_____
Street Apt City State Zip

Date of Birth _____ Age____ Social Security#_____

Female ___ Male ___ Minor____Single____ Married____ Widowed____ Other_____

Home Phone _____Secondary Phone _____

If under 21, parents name _____Phone _____

Employer _____Business Phone_____

Emergency Contact _____Phone _____
(Not living with patient)

Primary Physician _____ Phone_____

---

## MEDICAL INSURANCE INFORMATION

**Primary Insurance Co.** _____
Policy
Number_____ Group _____ Copay_____

Policy Holder - _____Self _____Spouse _____Parent _____ Guardian

Policy Holder Name: _____ Employer: _____
(If different from patient)
**Secondary Insurance Co.**_____
Policy
Number_____ Group _____

Policy Holder - _____Self _____Spouse _____Parent _____ Guardian

Policy Holder Name (If different from patient)_____

---

**Authorization:** I certify to the accuracy of the above listed information. I hereby authorize the release of any medical information necessary to process my health insurance claims and request payment of benefits to the provider of services. I understand I am financially responsible to Orthopedic Professional Association for charges not covered or denied by my insurance company. I further agree, in the event of my non-payment, to the cost of collection and/or court costs and reasonable fees should this be required. A copy of this authorization may be treated as an original.

Insured/Patient's Signature_____ Date: _____

If minor (17 or younger), parent or legal guardian must sign
Parent or legal guardian _____ Relationship_____

Printed name of parent or legal guardian _____