2011

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

Date of Birth _____ Age____ Social Security# _____

Female ___ Male ___ Minor____Single____ Married____ Widowed____Other_____

Race (Circle one) White Black / African American Asian Hispanic

Home Phone _____ Secondary Phone_____

If under 21, parents name_____ Phone _____

Employer _____ Business Phone _____

Emergency Contact_____ Phone _____
(Not living with patient)

Primary Physician _____ Phone _____

E-Mail Address _____

MEDICAL INSURANCE INFORMATION

Primary Insurance Co._____
Policy
Number _____ Group _____Copay_____

Policy Holder - _____Self _____Spouse _____Parent ___Guardian

Policy Holder Name:_____**DOB:**_____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. Orthopedic Professional Association is not party to any legal agreements between divorced or separated parents. I further agree, in the event of my non-payment, to the collection agency cost and/or court costs and/or attorney fees 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 _____