# *Patient Information*

Thank you for choosing our office! In order to serve you properly, we need the following information.
Please print. All information will be confidential.

| First Name | Middle Initial | Last Name | | |
|---|---|---|---|---|
| Address | | City | State | Zip |
| Home Phone | Cell Phone | Work Phone | | |

| Age | Date of Birth | Sex M F | Social Security # | Marital status S M D W | E-mail Address |
|---|---|---|---|---|---|

| Reason for Visit | Result of Accident? YES NO | Date of accident? | Time? ( A/P) | Auto? YES NO | State? | Work Related? YES NO |
|---|---|---|---|---|---|---|

If Accident, how & where did the accident occur?

| Referred by: | PCP: | PCP Phone # |
|---|---|---|
| Employer's Name | Employer's Address | Phone |

Primary Insurance ______________ Member ID ______________ Group ID ______________
Name of Insured ______________ Relationship to patient ______________
Birthdate ______________ Social Security # ______________
Name of employer ______________ Work phone ______________

Do you have additional insurance? Yes No If yes, complete the following:

Secondary Insurance ______________ Member ID ______________ Group ID ______________
Name of Insured ______________ Relationship to patient ______________
Birthdate ______________ Social Security # ______________
Name of employer ______________ Work phone ______________

**If patient is a minor (under age 18), please complete the following:**

| Father | Mother |
|---|---|
| Father's name ______________ | Mother's name ______________ |
| Address ______________ | Address ______________ |
| City ______________ State ______ Zip ______ | City ______________ State ______ Zip ______ |
| Phone H) ______________ W) ______________ | Phone H) ______________ W) ______________ |
| C) ______________ | C) ______________ |
| Employer | Employer |

**Emergency Contact:** ______________ Phone ______________
Relationship: ______________

**ASSIGNMENT OF BENEFITS**

I hereby assign all medical and/or surgical benefits to include major medical benefits to which I am entitled including private insurance to BROKEN ARROW BONE & JOINTS SPECIALISTS. This assignment will remain in affect until revoked by me in writing. I understand that I am financially responsible for all charges whether or not paid by said insurance. I hereby authorize said assignee to release all information necessary to secure the payment of said benefits.

**TREATMENT CONSENT**

I hereby consent to all medical treatment, therapy, X-Ray, and procedures performed by BROKEN ARROW BONE & JOINT SPECIALISTS and/or personnel. The signature below indicates agreement to assignment of benefits, financial responsibility as well as consent to treat.

______________________________ ______________
Signature of Patient (or parent, if minor) Date