

DR _____ DATE _____ TIME _____ CHART # _____

PATIENT INFO	NAME - LAST	FIRST	MIDDLE	BIRTH DATE	AGE	SEX	SS #
	STREET ADDRESS			HOME PHONE ()		WORK PHONE ()	
	CITY	STATE	ZIP CODE	CELL PHONE ()		EMAIL	
	EMPLOYER			STUDENT (CHECK ONE) <input type="checkbox"/> YES <input type="checkbox"/> NO		MARITAL STATUS	
	ADDRESS			SPOUSE NAME		SPOUSE EMPLOYER	
	CITY	STATE	ZIP CODE	SPOUSE CELL PHONE ()		SPOUSE WORK PHONE ()	

GUARANTOR	NAME	EMPLOYER	
	ADDRESS	ADDRESS	
	CITY, STATE	ZIP CODE	CITY, STATE
	RELATION TO PATIENT	WORK PHONE	ZIP CODE
	HOME PHONE	MUST COMPLETE: IN CASE OF EMERGENCY, NAME OF FRIEND OR RELATIVE NOT LIVING WITH YOU	
	SOCIAL SECURITY NUMBER	PHONE	RELATIONSHIP

INSURANCE	INSURANCE (Please check one): <input type="checkbox"/> No Coverage <input type="checkbox"/> Auto Insurance <input type="checkbox"/> BCBS <input type="checkbox"/> CHAMPUS <input type="checkbox"/> HMO <input type="checkbox"/> Medicaid <input type="checkbox"/> Medicare <input type="checkbox"/> PPO <input type="checkbox"/> Workman's Comp. <input type="checkbox"/> Other					
	PRIMARY COMPANY			SECONDARY COMPANY		
	ADDRESS			ADDRESS		
	CITY, STATE			ZIP CODE		
	SUBSCRIBER'S NAME			D.O.B.		SEX
	POLICY #			POLICY #		
	ID #		GROUP #	ID #		GROUP #
	SS #		RELATION TO PATIENT	SS #		RELATION TO PATIENT

REFERRAL INFO	REFERRING PHYSICIAN - (CHECK BOX IF REFERRED THRU ER) <input type="checkbox"/> ER				CITY, STATE	
	X-RAYS <input type="checkbox"/> YES <input type="checkbox"/> NO	X-RAY TAKEN AT	X-RAY DATE	X-RAYS WITH PATIENT <input type="checkbox"/> YES <input type="checkbox"/> NO	FAMILY PHYSICIAN - CITY, STATE	
	ACCIDENT <input type="checkbox"/> YES <input type="checkbox"/> NO	ACCIDENT OCCURRED <input type="checkbox"/> WORK <input type="checkbox"/> HOME <input type="checkbox"/> AUTO <input type="checkbox"/> OTHER		ACCIDENT STATE	ACCIDENT DATE	REASON FOR SEEING DOCTOR
	ATTY INVOLVED <input type="checkbox"/> YES <input type="checkbox"/> NO		IF YES, ATTORNEYS NAME AND PHONE NUMBER			

SIGNATURES	RELEASE OF MEDICAL INFORMATION	
	AUTHORIZATION TO PAY BENEFITS TO PHYSICIAN: I hereby assign payment directly to Advanced Orthopaedic Associates, P.A., for the surgical and/or medical benefits, if any, otherwise payable to me for services as described, but not to exceed my indebtedness to Advanced Orthopaedic Associates, P.A., for those services.	
	INSURANCE INFORMATION RELEASE AUTHORIZATION: I hereby authorize Advanced Orthopaedic Associates, P.A., to release any information acquired in the course of my examination or treatment to my referring doctor and/or my insurance company or employer.	
	FINANCIAL AGREEMENT: I understand that I am responsible for all fees, regardless of insurance coverage. See separate Financial Policy/Agreement.	
	PATIENT'S SIGNATURE: _____	DATE _____
INSURED'S SIGNATURE (if other than patient) _____	DATE _____	