DECATUR ORTHOPAEDIC CLINIC

(PLEASE PRINT)

PT# ____________________

DATE ________________ ACCT TYPE ____________

PATIENT INFORMATION

PATIENT'S NAME	SOC SEC #	BIRTH DATE	AGE	M F	MARITAL STATUS S M W D
PATIENT'S ADDRESS	CITY	STATE ZIP	HOME PHONE #		CELL PHONE #
PATIENT'S EMPLOYER		CITY			BUSINESS PHONE #
SPOUSE'S NAME	ADDRESS (IF DIFFERENT)	SPOUSE'S SOC SEC #			SPOUSE'S BIRTH DATE
SPOUSE'S EMPLOYER		CITY			BUSINESS PHONE #
NAME AND ADDRESS OF OTHER CONTACT (NOT LIVING AT YOUR RESIDENCE)		CITY	RELATION TO PATIENT		HOME PHONE #
HAVE YOU SEEN ANY OF OUR DOCTORS IN THE PAST? Y N		IF YES, PLEASE GIVE AN APPROXIMATE DATE			

COMPLETE IF PATIENT IS A MINOR OR STUDENT

FATHER'S NAME	ADDRESS	CITY	STATE	ZIP	HOME PHONE #
FATHER'S SOC SEC #	BIRTH DATE	EMPLOYER			BUSINESS PHONE #
MOTHER'S NAME	ADDRESS	CITY	STATE	ZIP	HOME PHONE #
MOTHER'S SOC SEC #	BIRTH DATE	EMPLOYER			BUSINESS PHONE #

RESPONSIBLE PARTY AND INSURANCE INFORMATION

PERSON RESPONSIBLE FOR PAYMENT	ADDRESS (IF DIFFERENT FROM ABOVE)	PHONE #	RELATION TO PATIENT
PRIMARY INSURANCE COMPANY	POLICY #	GROUP #	
POLICY SUBSCRIBER'S NAME (AS ON CARD)	BIRTH DATE	SOC SEC #	RELATION TO PATIENT
SECONDARY INSURANCE COMPANY	POLICY #	GROUP #	
POLICY SUBSCRIBER'S NAME (AS ON CARD)	BIRTH DATE	SOC SEC #	RELATION TO PATIENT

WORKMAN'S COMPENSATION INFORMATION

DATE OF INJURY?	EMPLOYER AT TIME OF INJURY?	ADDRESS	CITY	STATE
HOW AND WHERE WAS INJURY SUSTAINED?				
NAME OF CONTACT PERSON TO VERIFY WORKMAN'S COMP				PHONE #

I hereby assign to and authorize payment directly to Decatur Orthopaedics for benefits payable from participating insurance companies. I realize the insurance, workman's compensation, and/or liability claims may not pay all of the charges. I agree to pay the difference or the entire bill if necessary.

SIGNED ____

FORM #CC-716-99 (REV. 3/05)