

Chief Complaint \_\_\_\_\_ Office Use Only DOI \_\_\_\_\_

**PATIENT INFORMATION**

Date \_\_\_\_\_ Referred by \_\_\_\_\_

Primary Care Physician \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_

Last Name \_\_\_\_\_ First Name \_\_\_\_\_ Middle Name \_\_\_\_\_

Street \_\_\_\_\_ City \_\_\_\_\_

State \_\_\_\_\_ Zip \_\_\_\_\_ SSN \_\_\_\_\_ Marital Status \_\_\_\_\_

Phone: Home \_\_\_\_\_ Cell \_\_\_\_\_ Business \_\_\_\_\_

Email Address (please print legibly): \_\_\_\_\_

Age \_\_\_\_\_ Date of Birth (DOB) (mm/dd/yyyy) \_\_\_\_\_  Male  Female

**PATIENT  
INFO**

Employer's Name \_\_\_\_\_ Occupation \_\_\_\_\_

Spouse / Domestic Partner's Name \_\_\_\_\_ SSN \_\_\_\_\_

Employer's Name \_\_\_\_\_ Occupation \_\_\_\_\_

If patient is a minor:

Father's name \_\_\_\_\_ DOB \_\_\_\_\_ SSN \_\_\_\_\_

Mother's Name \_\_\_\_\_ DOB \_\_\_\_\_ SSN \_\_\_\_\_

Who accompanies you to appointments? \_\_\_\_\_

Who can we share medical information with? \_\_\_\_\_

**PERSON  
RESPONSIBLE  
FOR  
PAYMENT**

Name \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

Street \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

SSN \_\_\_\_\_ DOB \_\_\_\_\_ Employer \_\_\_\_\_

Phone: Home \_\_\_\_\_ Business \_\_\_\_\_ Cell \_\_\_\_\_

**EMERGENCY  
CONTACT**

Name \_\_\_\_\_ Relationship \_\_\_\_\_

Phone \_\_\_\_\_

**ACCIDENT  
OR INJURY  
DETAILS**

Auto  On The Job  Other Date \_\_\_\_\_ Time \_\_\_\_\_ AM/PM

Details (what happened?) \_\_\_\_\_

Location of Accident \_\_\_\_\_

Signed \_\_\_\_\_ Date \_\_\_\_\_

If the condition for which you are seeing one of our doctors involves litigation, as may result from an automobile accident or fire, be advised that we do not wait for payment until the litigation is settled, but we will accept regular monthly payment on account.

**PRIMARY  
INSURANCE  
SECONDARY  
INSURANCE**

Ins. Co. \_\_\_\_\_ I.D. No. \_\_\_\_\_ Policy or Group No. \_\_\_\_\_

Subscriber \_\_\_\_\_ SSN \_\_\_\_\_ Relationship \_\_\_\_\_ DOB \_\_\_\_\_

Ins. Co. \_\_\_\_\_ I.D. No. \_\_\_\_\_ Policy or Group No. \_\_\_\_\_

Subscriber \_\_\_\_\_ SSN \_\_\_\_\_ Relationship \_\_\_\_\_ DOB \_\_\_\_\_

I authorize release of information in my medical history to Medicare and/or my insurance companies and assign all benefits for unpaid services to Cascade Orthopaedic Group

Signed \_\_\_\_\_ Date \_\_\_\_\_

(A photostatic copy of this authorization shall be considered effective and valid as the original)