Chief Complaint _____ **Office Use Only** DOI _____

PATIENT INFORMATION

Date _____ **Referred by** _____

Primary Care Physician _____ **City** _____ **State** _____

PATIENT INFO

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

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

Ins. Co._____ I.D. No._____ Policy or Group No. _____

Subscriber _____SSN_____ Relationship_____DOB_____

SECONDARY INSURANCE

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)