

PATIENT INFORMATION

Patient Name Birthdate Age Mailing Address Home/Cell Phone City State Zip Soc. Sec # Marital Status Sex Occupation Employer's Address Work Phone Spouse's Name DOB Soc. Sec # Employer Work Phone In Case of Emergency Please Contact Phone Referred by Phone Drug Allergies

PARENT / GUARDIAN INFORMATION IF PATIENT IS A MINOR

Father/Guardian Name DOB Soc. Sec # Address (if different from patient) City State Zip Home Phone Employer Phone Mother/Guardian Name DOB Soc. Sec # Address (if different from patient) City State Zip Home Phone Employer Phone

HEALTH INSURANCE (PLEASE PRESENT YOUR CARD TO RECEPTIONIST)

Primary Insurance Phone Address City State Zip Insured Name Soc. Sec # DOB Policy ID # Group # Secondary Insurance Address City State Zip Insured Name Soc. Sec # DOB Policy ID # Group #

ACCIDENT INFORMATION (IF APPLICABLE)

Date of Accident Worker's Compensation or Auto Accident or Other Part of Body Injured Accident Happened in Which State Insurance Carrier Phone Address City State Zip Claim or Policy # Name of Adjuster Employer (if different from above) Phone

ASSIGNMENT AND RELEASE OF INFORMATION

NOTE: Insurance Pre-Authorization: It is the patient's responsibility to notify this office if your insurance carrier requires pre-authorization for any services. Assignment and Release of Information: I hereby authorize Missoula Bone & Joint to release any information acquired in the course of my examination and treatment to the insurance company. I also authorize payment directly to the physician. By signing below, I recognize and accept responsibility for any balance remaining after payment of benefits.

Signature of Responsible Party Relationship to Patient Date

CONSENT TO TREAT

I also hereby request and consent to treatment and services reasonable and proper by today's standards provided by a provider of Missoula Bone & Joint and any employee acting under my provider's orders.

Signature of Responsible Party Relationship to Patient Date