

Please fill out both sides of this form completely. All information is necessary in order for us to file with your insurance. Please print.

Office 0 1

Today's date: _____

Information Regarding Patient:

Last		First		Middle	
Name:					
Address:					
City:		State:		Zip Code:	
Home Phone: ()			Mobile: ()		
Your Physician (CIRCLE ONE): Cox Jablonsky Nixon Samuelson Havenhill Basran Gent Patel					
Social Security Number:			Primary Care Doctor:		
Male / Female		Marital Status:		Date of Birth:	
Who Referred you to this Office?					
Patient's Employer:					
Employer's Phone Number:					
Employment Status (CIRCLE ONE):		Full Time	Part Time	Unemployed	
Student Status (CIRCLE ONE):		Full Time	Part Time	N/A	

Please List any Medications you are Taking:					
Please List any Medications you are Allergic To:					

Is Your Injury Related To: Motor Vehicle Accident () yes () no
Work Related Injury () yes () no

In Case of Emergency, Contact (Nearest Relative *NOT* living with you):

Name: _____ Phone: _____
Address: _____
Relation to Patient: _____

Information Regarding Insurance Policy:

Primary Insurance Company Name:		
Name of Policy Holder:		
Address of Policy Holder:		
City:	State:	Zip Code:
Telephone Number:	Mobile:	
Policy Holder Social Security #:		
Birth Date of Policy Holder:	Male / Female	
Policy Holder's Employer:		
Policy Holder's Work Phone Number:		

Secondary Insurance Company Name:		
Name of Policy Holder:		
Address of Policy Holder:		
City:	State:	Zip Code:
Telephone Number:	Mobile:	
Policy Holder Social Security #:		
Birth Date of Policy Holder:	Male / Female	
Policy Holder's Employer:		
Policy Holder's Work Phone Number:		

AUTHORIZATION TO PAY BENEFITS TO PHYSICIAN AND TO RELEASE INFORMATION:

I HEREBY AUTHORIZE PAYMENT DIRECTLY TO McHENRY COUNTY ORTHOPAEDICS FOR THE SURGICAL AND/OR MEDICAL BENEFITS, IF ANY, OTHERWISE PAYABLE TO ME FOR THE SERVICES RENDERED. I HEREBY AUTHORIZE THE UNDERSIGNED PHYSICIAN TO RELEASE ANY INFORMATION ACQUIRED IN THE COURSE OF MY EXAMINATION OR TREATMENT. I UNDERSTAND THAT THE PROCESSING OF INSURANCE BY McHENRY COUNTY ORTHOPAEDICS IS DONE AS A COURTESY TO ME, AND THAT I AM ULTIMATELY RESPONSIBLE FOR PAYMENT OF THE MEDICAL BILLS INCURRED. IN THE EVENT THE ACCOUNT MUST BE REFERRED TO COLLECTION, I AGREE TO BE RESPONSIBLE FOR THE COSTS OF COLLECTION, INCLUDING REASONABLE ATTORNEY'S FEES, IF ANY.

Signed (PATIENT) X _____

Signed (PATIENT'S GUARDIAN)
X _____