

Patient Account No. _____ Doctor _____ Date _____

Is this visit due to any accident? YES NO If yes: _____ Motor Vehicle _____ Work Related _____ Other? _____

Method of Payment Today: Cash Check Visa/MC Insurance SELF PAY

(PATIENT INFORMATION) EVER SEEN UNDER OR KNOWN BY OTHER NAME _____

LAST NAME		FIRST NAME		MIDDLE INITIAL	
GENDER <input type="checkbox"/> M <input type="checkbox"/> F	DATE OF BIRTH -- --	SS # -- --		MARITAL STATUS <input type="checkbox"/> MARRIED <input type="checkbox"/> SINGLE <input type="checkbox"/> DIVORCED <input type="checkbox"/> WIDOW	
RACE		ETHNICITY		PREFERRED LANGUAGE	
ADDRESS		CITY	STATE	ZIP CODE	HOME PHONE () --
PATIENT'S EMPLOYER		PATIENT'S OCCUPATION		<input type="checkbox"/> FULLTIME <input type="checkbox"/> PART TIME	WORK PHONE () --
IS THE PATIENT A STUDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO	IF YES, NAME AND CITY OF SCHOOL			CELL PHONE () --	
E-MAIL ADDRESS	-----@-----.				
IN CASE OF EMERGENCY (SOMEONE NOT LIVING WITH YOU)		RELATIONSHIP TO PATIENT	HOME PHONE () --		WORK / CELL PHONE () --

(GUARANTOR) PERSON RESPONSIBLE FOR THE BILL IF PATIENT IS A MINOR OR STUDENT

FULL NAME		RELATIONSHIP	HOME ADDRESS	CITY	STATE	ZIP
HOME PHONE () --	WORK PHONE () --	CELL PHONE () --	DOB -- --	SS# -- --		

(INSURANCE INFORMATION) * COPIES OF YOUR INSURANCE CARDS ARE REQUIRED

INSURANCE #1 (PRIMARY INSURANCE)		INSURANCE #2 (SECONDARY INSURANCE)	
INSURED'S NAME	RELATIONSHIP TO PATIENT	INSURED'S NAME	RELATIONSHIP TO PATIENT
SOCIAL SECURITY # OF INSURED (IF DIFFERENT FROM PATIENT) -- --		SOCIAL SECURITY # OF INSURED (IF DIFFERENT FROM PATIENT) -- --	
DATE OF BIRTH OF INSURED -- --		DATE OF BIRTH OF INSURED -- --	
INSURED'S EMPLOYER (IF DIFFERENT FROM PATIENT)		INSURED'S EMPLOYER (IF DIFFERENT FROM PATIENT)	

I hereby acknowledge that by providing insurance information, I have asked and promised to pay for services provided in exchange for this information. I understand that fees for services provided by Midlands Orthopaedics are my responsibility and I agree to pay any balance left unpaid by any insurance company or third party entity immediately upon notification of said balance. If I do not have insurance, I understand that I am responsible for any incurred expenses in their entirety.

Patient or Guarantor

Date