

# Orthopedic & Fracture Clinic Patient Profile

Doctor: \_\_\_\_\_

<b><u>PATIENT INFORMATION</u></b>		Patient ID #:	Sex: [ ]M [ ]F
Name: _____		Date of Birth: _____	
Address: _____		Social Security #: _____	
		Marital Status: [ ]Married [ ]Single [ ]Divorced	
City, State, Zip: _____		E-Mail Address: _____	
Phone: _____ [ ]Home [ ]Work [ ]Other		Referring Physician: _____	
Phone: _____ [ ]Home [ ]Work [ ]Other		Primary Physician: _____	

**Race/ethnicity (check all that apply)**

<input type="checkbox"/> American Indian or Alaskan Native	<input type="checkbox"/> Asian	<input type="checkbox"/> Unknown
<input type="checkbox"/> Black or African American	<input type="checkbox"/> White	<input type="checkbox"/> Other
<input type="checkbox"/> Native Hawaiian or Pacific Islander	<input type="checkbox"/> Hispanic	<input type="checkbox"/> Decline

<b><u>PATIENT'S EMPLOYMENT INFORMATION</u></b>	<b><u>EMERGENCY CONTACTS OUTSIDE THE HOME</u></b>
[ ]Employed [ ]Retired [ ]Other	Name                      Relationship                      Phone
Phone: _____	_____
Employer: _____	_____

<b><u>GUARANTOR INFORMATION</u></b>	[ ]Same as Patient
Name: _____	Employer: _____
Address: _____	Phone: _____
City, State, & Zip : _____	Phone 2: _____
	SSN: _____
	Date of Birth: _____

<b><u>PRIMARY INSURANCE INFORMATION</u></b>	<b><u>SECONDARY INSURANCE INFORMATION</u></b>
[ ]Same as Patient [ ]Same as Guarantor [ ]Other	
Insured Party Name: _____	Insured Party: _____
Insured Phone: _____	Insured Phone: _____
Insured's Employer: _____	Insurance Company: _____
Insurance Company: _____	Relationship to Patient: _____
Relationship to Patient: _____	Social Security #: _____
Social Security #: _____	Insured ID: _____
Insured ID: _____	Policy Group: _____
Policy Group: _____	Date of Birth: _____
Insured's Date of Birth: _____	

<b><u>IF WORK INJURY</u></b>		
Insurance Carrier Name _____	Address: _____	
City, State, & Zip: _____	Phone: _____	
Claim Number: _____	Employer @ time of Injury: _____	Date of Injury: _____