

**PATIENT INFORMATION**

Name (First) \_\_\_\_\_ (MI) \_\_\_\_\_ (Last) \_\_\_\_\_  
Date of Birth \_\_\_\_\_ Age \_\_\_\_\_ Sex:  M  F Marital Status:  S  M  W  D  
Address: \_\_\_\_\_ City, State, ZIP \_\_\_\_\_  
Home Phone # \_\_\_\_\_ Social Security # \_\_\_\_\_ Driver License # \_\_\_\_\_  
Occupation \_\_\_\_\_ Full time or Part time \_\_\_\_\_ Work comp or auto acct.? \_\_\_\_\_  
Work # \_\_\_\_\_ Employer Name \_\_\_\_\_ Attorney contacted? \_\_\_\_\_  
Employer's Address \_\_\_\_\_ City, State & Zip \_\_\_\_\_  
If Student, School Name \_\_\_\_\_ Full or Part Time \_\_\_\_\_ Referring Physician \_\_\_\_\_  
Primary care Doctor \_\_\_\_\_ Address or Office Location \_\_\_\_\_ Phone # \_\_\_\_\_  
How did you hear about us? \_\_\_\_\_

**RESPONSIBLE PARTY OR SPOUSE INFORMATION**

Name \_\_\_\_\_ Relationship to Patient \_\_\_\_\_  
Address (Street) \_\_\_\_\_  
(City, State, ZIP) \_\_\_\_\_  
Home Phone # \_\_\_\_\_ Social Security # \_\_\_\_\_ Driver License # \_\_\_\_\_  
Work # \_\_\_\_\_ Employer Name \_\_\_\_\_  
Employer's Address \_\_\_\_\_  
Friend or Relative Not Living With You \_\_\_\_\_ Phone # \_\_\_\_\_

**INSURANCE INFORMATION (POLICY HOLDER)**

Insurance Co. \_\_\_\_\_ Phone # \_\_\_\_\_  
Insurance Address \_\_\_\_\_  
Group # \_\_\_\_\_ Certificate or I.D. # \_\_\_\_\_  
Guarantor's Name \_\_\_\_\_ Relationship to Patient:  Self  Spouse  Dependent  Other  
Guarantor's Employer \_\_\_\_\_ Phone # \_\_\_\_\_  
Employer's Address \_\_\_\_\_  
Guarantor's Social Security # \_\_\_\_\_ Date of Birth \_\_\_\_\_ Sex:  M  F

If the patient is covered by another insurance policy, please complete the following information for coordination of benefits. This information will enable your insurance company to process your claim more quickly. Thank you!

**SECONDARY INSURANCE INFORMATION**

Insurance Co. \_\_\_\_\_ Phone # \_\_\_\_\_  
Insurance Address \_\_\_\_\_  
Group # \_\_\_\_\_ Certificate or I.D. # \_\_\_\_\_  
Guarantor's Name \_\_\_\_\_ Relationship to Patient:  Self  Spouse  Dependent  Other  
Guarantor's Employer \_\_\_\_\_ Phone # \_\_\_\_\_  
Employer's Address \_\_\_\_\_  
Guarantor's Social Security # \_\_\_\_\_ Date of Birth \_\_\_\_\_ Sex:  M  F

I hereby assign, transfer, and set over to Advanced Orthopaedic Surgery Center all of my rights, title, and interest to my medical reimbursement benefits under my insurance policy. I authorize the release of any medical information needed to determine these benefits. This authorization shall remain valid until written notice is given by me revoking said authorization. I understand that I am financially responsible for all charges whether or not they are covered by insurance. I certify all information is true and correct. A copy of my signature is as valid as the original.

Patient's Signature \_\_\_\_\_ Date \_\_\_\_\_