



John Place Orthopedics

HAVE YOU BEEN IN OUR CLINIC BEFORE?	
_____ YES	_____ NO

PLEASE PRINT

PATIENT INFORMATION

PATIENT'S NAME: Last		First: Middle	Age	Birthdate	
			Sex	M <input type="checkbox"/>	Social Security #
			F <input type="checkbox"/>		
MAILING ADDRESS: Street		City		State/Zip	
HOME PHONE ()		MARITAL STATUS Single Married Widow/er Divorced Separated			
EMPLOYER			WORK PHONE ()		
EMPLOYER ADDRESS					
IF MARRIED: SPOUSE'S NAME			SPOUSE'S BIRTHDATE _____		
SPOUSE'S EMPLOYER			SPOUSE'S WORKPHONE _____		
REFERRING PHYSICIAN OR PERSON					

IF PATIENT IS A MONOR

FATHER'S NAME		HOME PHONE ()			
ADDRESS: Street		City		State/Zip	
BIRTHDATE:	SS#	EMPLOYER NAME	WORK PHONE ()		
MOTHER'S NAME		HOME PHONE ()			
ADDRESS: Street		City		State/Zip	
BIRTHDATE:	SS#	EMPLOYER NAME	WORK PHONE ()		

STATE INDUSTRIAL

IS THIS VISIT THE RESULT OF A WORK-RELATED INJURY? _____ YES _____ NO					
If "Yes" : _____ State Industrial (L&I) _____ Self-Insured Employer					
IF SELF-INSURED: NAME AND ADDRESS OF INSURANCE COMPANY					
DATE OF INJURY		CLAIM#	EMPLOYER AT TIME OF INJURY		
Month	Day				
EMPLOYER PHONE					

PRIMARY INSURANCE COMPANY

INSURANCE COMPANY NAME		GROUP # / POLICY # / DSHS # / MEDICARE #			
INSURANCE COMPANY ADDRESS					
SUBSCRIBER'S NAME		SOCIAL SECURITY #	BIRTHDATE		
EMPLOYER NAME (If group insurance)					

SECONDARY INSURANCE COMPANY

INSURANCE COMPANY NAME		GROUP # / POLICY # / DSHS # / MEDICARE #			
INSURANCE COMPANY ADDRESS					
SUBSCRIBER'S NAME		SOCIAL SECURITY #	BIRTHDATE		
EMPLOYER NAME (If group insurance)					

IS THERE ANY SOURCE OF PAYMENT OTHER THAN THOSE LISTED ABOVE _____ Yes _____ No

EMERGENCY CONTACT

PERSON TO CALL IN CASE OF EMERGENCY (not living with you)		
NAME	PHONE #	RELATIONSHIP