

PATIENT DEMOGRAPHICS		FOLSOM ORTHOPAEDIC SURGERY			
First Name		MI	Last Name		
Address					
City			ST	ZIP	
DOB / /	Marital Status		S	M	D W
Sex			M	F	SS
Primary Phone to reach you ()			Other Number ()		
Employer			Occupation		
May we leave information on your voice mail/machine? Yes No					
Who Referred you? Physician Family Friend Insurance Other					
Referring Physician's Name					
In the event of an emergency please contact					
Name		Relationship		Phone ()	
Minor Patients Name of Parent/Guardian					
Address if different from above					
Divorced or separated parents: It is our office policy that the parent accompanying the child for treatment will be held responsible for all bills; we cannot bill the other parent.					
Insurance Information					
Primary Insurance			Policy Holder Name		
Relationship to Insured		Self	Spouse	Child	Other
					Insured's DOB
ID#			Group#		
Secondary Insurance			Policy Holder Name		
Relationship to Insured		Self	Spouse	Child	Other
					Insured's DOB
ID#			Group#		
IF YOUR INJURY IS JOB RELATED OR A PERSONAL INJURY, PLEASE SEE STAFF IMMEDIATELY					

NOTICE REGARDING INSURANCE CLAIMS/PAYMENTS:

If we are filing an insurance claim for your visit, we must have complete information and any required referral at the time of the visit. If you cannot provide the information, we will be unable to file your claim and payment in full will be required.

Payment of your charges cannot be determined until the claim is submitted to your insurance company. Payment will be based on your health plan and the amount applied to you plan deductible and/or coinsurance will be your responsibility. Procedures which are excluded from coverage based on your plan's determination of medical necessity will also be your responsibility. Your office visit co-pay is due at the time of the visit. If you have a deductible plan, we will collect a deposit towards your visit.

I assign and request payment of medical and surgical benefits to Folsom Orthopaedic Surgery & Sports Injury Medical Clinic, Inc. for services rendered. I hereby authorize said assignee to furnish information necessary to process my claim and to forward medical records for continuation of medical care. I understand that I am financially responsible for any unpaid balance within 30 days of my visit. A photocopy of this authorization shall be as valid as the original.

Date: _____ Signature: _____