Dominion Orthopedic Clinic

PATIENT INFORMATION

NAME*_____

DATE OF BIRTH*_____

ADDRESS*

Street Address_____

City_____

State / Province / Region_____

ZIP / Postal Code_____

HOME PHONE_____

WORK PHONE_____

CELL PHONE*_____

SOCIAL SECURITY NUMBER*_____

SEX* ___MALE ___FEMALE

EMPLOYER*_____

EMERGENCY CONTACT*_____

EMERGENCY PHONE*_____

EMERGENCY RELATIONSHIP*_____

GUARANTOR INFORMATION

NAME*_____

DATE OF BIRTH*_____

ADDRESS*

Street Address_____

City_____

State / Province / Region_____

ZIP / Postal Code_____

HOME PHONE_____

WORK PHONE_____

CELL PHONE*_____

SOCIAL SECURITY NUMBER*_____

EMPLOYER*_____

Address*

Street Address_____

Address Line 2_____

City_____

State / Province / Region_____

ZIP / Postal Code_____

INSURANCE INFORMATION

Primary Insurance*_____

Certificate #*_____

Group Number*_____

Group Name*_____

Copay*_____

Subscriber Name*_____

Secondary Insurance*_____

Certificate #*_____

Group Number*_____

Group Name*_____

Copay*_____

Subscriber Name*_____

ADDITIONAL INFORMATION

Primary Care Physician*_____

Physician Phone Number*_____

Physician Fax*_____

Physician Address*

Street Address_____

Address Line 2_____

City_____

State / Province / Region_____

ZIP / Postal Code_____

Pharmacy Name*_____

Pharmacy Phone Number*_____

Pharmacy Fax*_____

Pharmacy Address*

Street Address_____

Address Line 2_____

City_____

State / Province / Region_____

ZIP / Postal Code_____

COMPLETE INFORMATION BELOW IF APPLICABLE

Attorney Name*_____

Attorney Phone*_____

Attorney Address

Street Address_____

Address Line 2_____

City_____

State / Province / Region_____

ZIP / Postal Code_____

Adjuster Name*_____

Adjuster Phone*_____

Adjuster Fax*_____

Date Of Injury*_____

Authorization To Pay Benefits To Physician: I authorize the release of medical or other information necessary to process health insurance claims. I also request payment of benefits to myself or Dominion Orthopedic Clinic when they accept assignment.

Authorization To Release Medical Information. I hereby authorize Dominion Orthopedic Clinic to release any information necessary for my course of treatment.

Signature*_____

Date*_____