

South Bay Orthopaedic Specialists Medical Center
PATIENT INFORMATION MINOR

WELCOME TO OUR OFFICE! PLEASE PRINT.

First Name

Last Name

Patient's Name: _____ Sex: M F Birth Date: _____ Age: _____

Address: _____ Home Phone(____) _____

City: _____ State: _____ Zip: _____ Message Phone (____) _____

Patient Social Sec:#: _____ Parent CA Dr. Lic.#: _____

Parent Name: _____ SS#: _____

Parent Employer: _____ Parent Occupation: _____

Parent's Business Address: _____ Phone: (____) _____ ext _____

Name of Referring Physician /Pediatrician: _____

Emergency Contact: _____ Relationship: _____ Phone: (____) _____

*******INSURANCE*******

In addition to a copy of your insurance card, this section must be fully completed in order for us to courtesy bill your insurance company.

PRIMARY Insurance Co.: _____ Insured: _____

Insured Employer: _____ DOB: _____ Insured SS#: _____

Policyholder's relationship to patient: _____

SECONDARY Insurance Co. _____ Insured: _____

Insured Employer: _____ DOB: _____ Insured SS#: _____

Policyholder's relationship to patient: _____

Person responsible for payment; if not the insured? _____ Phone:(____) _____

*******PRESENT COMPLAINT*******

Date of Injury or estimated first date of symptoms: _____ **Body Part(s) Injured:** _____

Was your injury related to an accident? YES NO Was an automobile involved? YES NO

(Circle One)

(Circle One)

If you have an attorney; what is your attorney's name: _____ Phone#: (____) _____

*******BASIC HEALTH HISTORY*******

Have you ever had a serious disease, or illness? YES NO If yes, Please explain: _____

Are you: (Circle One) Right or left handed? Height: _____ Weight: _____

Do you have any allergies to medication or latex? YES NO If yes, please list: _____

*****AUTHORIZATION TO RELEASE INFORMATION AND ASSIGNMENT OF BENEFITS*****

I request that payment of authorized Medicare/Other Insurance Company benefits be made to South Bay Orthopedic Specialists Medical Center for any services furnished to me by the physician in that group who accepts assignment. Regulations pertaining to Medicare apply.

I authorize any holder of medical or other information about me to release to the Social Security Administration and Health Care Financing Administration or its intermediaries or carriers any information needed for this or a related Medicare claim/other Insurance Company claim. I permit a copy of this authorization to be used in place of the original. I understand that it is mandatory to notify the health care provider or any other party who may be responsible for paying for my treatment. (Section 1128B of the Social Security Act and 31 U.S.C. 3801-3812 provides penalties for withholding this information). Conditional payment of any charges resulting from 3rd party liability will be requested from the insurance company. At the time of settlement of 3rd party liability cases insured will be responsible for reimbursing the insurance company for payments made and payment in full for all medical charges incurred in this office relating to said injury.

I understand that payment is my obligation and responsibility, regardless of insurance or other third party involvement. If your check is returned by the bank, a \$20.00 service charge will be added to your account.

I have read and understand my possible financial responsibility for services rendered and hereby affix signature as an acknowledgment of this understanding.

SIGNATURE OF PATIENT/LEGAL GUARDIAN

DATE

Office Use only. JU DS NS RO AL SN MW DZ HCP W/C PVT CASH OTHR _____INT ACCT#:_____