Name:
Chart:
Age:
Date:

**PATIENT INFORMATION FORM**

DATE: ____________

| Patient's Name (First, Middle, Last) | Date of Birth | Social Security No, |
|---|---|---|
| Patient's Address | Apt. No, | |
| City | State | Zip |
| Home Phone with Area Code | Cell Phone No. | Sex: ❑ M ❑ F |
| Primary Care Physician's Name | Phone with Area Code | |
| Referring Doctor | Address | City, State, Zip |

FILL IN IF PATIENT IS A MINOR

| Parent's Name (First, Middle, Last) | Date of Birth | Social Security No. |
|---|---|---|

ACCIDENT INFORMATION ❑ Work Injury ❑ Automobile Injury ❑ School/Sports Related ❑ Liability ❑ Other

Date of Accident and Description

| Employer at Time of Accident | Employer's Address | Phone with Area Code |
|---|---|---|

INSURANCE - PRIMARY

| Policy Holder's Name (If other than Patient) | Date of Birth | Social Security No, |
|---|---|---|
| Policy # | Group# | Phone with Area Code |
| Employer Name | Address | Phone with Area Code |

INSURANCE - SECONDARY

| Policy Holder's Name (If other than Patient) | Date of Birth | Social Security No, |
|---|---|---|
| Policy # | Group# | Phone with Area Code |
| Employer Name | Address | Phone with Area Code |

ASSIGNMENT OF MEDICAL BENEFITS/GUARANTEE OF FINANCIAL RESPONSIBILITY

I request that payment of authorized medical benefits be made directly to OrthoConnecticut. This assignment will remain in affect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original. I understand that I am Financially Responsible for all charges whether or not paid by said insurance. In the event that I fail to pay charges due and OrthoConnecticut refers my account to collection, I agree to pay cost of collections, including a reasonable attorneys' fee. For Medicare patients, this applies to the Social Security Administration, Centers for Medicare and Medicaid Services or its intermediaries or carriers.

Patient or Legal Guardian Signature ______________________ Date ____________