Welcome To Our Office

Name:____ Today's Date______________
First Middle Last

Home Address: ____
City: __________________________________ State: _______________ Zip: _________________________
Telephone ( ) :____________________ Birthday: _______________________________ Age:___________
Email Address: ____ May send information here? Yes / No
Occupation: ____ SSN:______________________
Employer: ____ Years There: ________
Employer's Address :____
City: ______________________________ State: _______________ Zip:____________
Work Phone ( ):______________________________ Preferred Language :___________________________
Race:_______________________Ethnicity:________________________Fulltime Student: Yes No

Complete this section only if someone other than the patient is financially responsible.

Responsible Party: __________________________________ Relationship to Patient:___________________
Home Address: ____
City: ________________________ State: _______________________ Zip:___________________________
Telephone ( ):_______________________ Birthday: ________________________________ Age:________
Occupation :____ SSN:___________________________
Employer:____ Years There:______
Employer's Address:____
City:________________________ State:__________________________ Zip:____________
Work Phone( ):__________________________________

Name of Spouse:____ Birthdate:_______________ Age______
Occupation:____ SSN:______________________________
Employer: ____ Years There:___________
Employer's Address:____
City:____________________________ State:____________________ Zip:___________
Employer's Telephone:( ):_________________________________

In case of emergency, contact:________________________________ Relationship:_____________________
Home Phone: ( )____________________________ Work Phone( )________________

What is the name of the physician that referred you to our office? __________________________________

Who is your primary care doctor? __________________________________

Would you like your primary care doctor to receive a copy of your office notes from the visit? Yes No

Do you wish correspondence to be confidential? Yes No
Do you wish phone calls to be confidential? Yes No
May we contact you at work? Yes No
May we leave a message at your home number? Yes No

Insurance Information

Today's Date: ______________________

Patient's Name:____ Patient's Date of Birth_____________
First Middle Last

(Primary Insurance)
Name of Insurance Company: ____
Address:____
City:____ State:____________________ Zip:__________________
Policy Holder's Name:____ DOB:_________________
Group Number:________________________________ Policy ID Number:______________________________

(Secondary Insurance)
Name of Insurance Company:____
Address:____
City:____ State:_________________ Zip:_____________________
Policy Holder's Name:____ DOB:________________
Group Number:________________________________ Policy ID Number:______________________________

Did your injury happen on the job? Yes No
If yes, on what date did the injury occur? ____________________
Did you report the accident to your employer? Yes No
On what date did you report the injury to employer? ____________________

Our office will file insurance for all reimbursable services, to both your primary and secondary insurance carriers. Please remember that you are responsible for all deductibles, co-pays, and non-covered service amounts. We must have copies of your insurance cards. Many insurance companies request a copy of the I.D. card before they will pay a claim. Please be patient if we ask to see you card frequently. We cannot help you get your medical bills paid until we satisfy the insurance companies..

Method of payment for today's visit: ____Cash ____Credit Card ____Debit Card

Assignment of Benefits:

I hereby authorize insurance benefits to be paid directly to Valdosta Orthopedic Associates. I understand I am responsible for any amounts not covered by my policies nor paid by my insurance companies.

Release of Information:
I authorize Valdosta Orthopedic Associates to release any information requested by my insurance company to insure prompt, accurate payment of my claims. I certify that the information furnished here is correct to the best of my knowledge.

Signature of Patient or responsible party:____

Signature of Insured:____