

PATIENT INFORMATION SHEET

Name: _____ e-mail address: _____

SSN: _____ DOB: _____ Sex: _____

Address: _____
Street City State Zip

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Marital Status: Single Married Widowed Separated Divorced

Spouse's name: _____

Employment Status: Full Time Part Time Retired Unemployed Disabled

Occupation: _____ Employer: _____

Employer Address: _____

Emergency Contact Name (not living with you): _____

Phone Number: _____ Relationship: _____

If patient is a minor or student, please fill out the following:

If you are a student check one: Full Time Part Time School: _____

Mother's Name: _____ Father's Name: _____

SSN: _____ DOB: _____ SSN: _____ DOB: _____

Address: _____ Address: _____

Contact Number _____ Contact Number _____

Insurance Information:

Do you have insurance? Yes No

Primary Insurance Carrier Information:

Insurance Company: _____

Insured Name: _____

Address: _____

SS#: _____ DOB: _____

Employer: _____

Home #: _____ Work#: _____

Relationship to Patient: _____

Secondary Insurance Carrier Information:

Insurance Company: _____

Insured Name: _____

Address: _____

SS#: _____ DOB: _____

Employer: _____

Home #: _____ Work#: _____

Relationship to Patient: _____

Please have your card available for copying

Workers Compensation Information

Did you injure yourself at work? Yes No

Date of injury: _____

Employer: _____

Employer's address: _____

Contact Name: _____

Have you notified your employer? Yes No

Occupation: _____

Contact number: _____

Auto Accident/Liability Accident

Is your injury the result of an auto accident? Yes No Date of Accident: _____

Have you retained an attorney as a result of this accident? Yes No

Attorney Name: _____ Phone Number: _____

Address: _____

Medical Information

Referring Physician: _____ Primary Care Physician: _____

Other Treating Physicians: _____

What body part are you being seen for today? _____ Left Right

Are you being seen as a result of an injury? Yes No

If Yes: Date of Injury: _____ If No: Date symptoms began: _____

If visit is for an injury, briefly describe how it occurred. _____

Have you had x-rays taken? Yes No If yes, where were they taken? _____

Do you have them with you today? Yes No

I will be paying by: Cash Check Credit Card

PATIENT FINANCIAL AGREEMENT

I agree it is my responsibility to provide The Orthopaedic Center of Central Virginia, Inc. with the correct billing information and I consent to the payment of medical benefits to The Orthopaedic Center of Central Virginia, Inc. and associated medical providers. I hereby authorize The Orthopaedic Center of Central Virginia, Inc. to release any medical information to insurance companies and appropriate third parties as determined by The Orthopaedic Center of Central Virginia, Inc. A photocopy of this authorization is to be considered as valid as the original until revoked by me in writing.

Payment is due at the time of service. I agree that I am financially responsible for all charges made to my account whether or not an insurance company, attorney, or other third party payor is involved with payment. I am responsible for all co-payment and co-insurance amounts, non-covered supplies and services and yearly deductibles. The Orthopaedic Center of Central Virginia, Inc. will file insurance as a courtesy. If The Orthopaedic Center of Central Virginia, Inc. participates with your insurance carrier we are contractually required to collect your financial portion at the time of services rendered. Returned checks are subject to a \$25.00 processing fee and a \$25 returned check fee.

I agree to pay all costs of collecting balances including but not limited to: legal fees, court costs, and attorney's fees, equal to one third (1/3) of the unpaid balance.

If you are unable to keep a scheduled appointment, and fail to notify our office within 24 hours of your appointment, a \$50.00 charge will be placed on your account. Once this charge is incurred we will be unable to schedule any future appointments for you until that balance has been paid.

I understand and agree to the above information and certify that the above information is true and correct.

Signature

Date