PATIENT INFORMATION (Please Print) DATE:

PATIENT'S NAME FIRST MIDDLE LAST	SEX ☐ M ☐ F	MARITAL STATUS S M W D	RACE	DATE OF BIRTH	AGE	SOCIAL SECURITY NO.

STREET ADDRESS	CITY AND STATE	ZIP CODE	HOME PHONE NO.
			( )

IF PATIENT IS A MINOR (MOTHER'S NAME/FATHER'S NAME) INCLUDE SOC. SEC. # AND DOB	**E-MAIL *(Important)***	CELL PHONE NO.
		( )

PATIENT'S EMPLOYER (NAME & ADDRESS)	WORK PHONE NO. (INCLUDE EXT.)
	( )

DESCRIBE YOUR JOB DUTIES (BE SPECIFIC)	ACTIVE RETIRED DISABLED DATE

PERSON TO CONTACT (OTHER THAN YOUR HOME PHONE NO.)	RELATIONSHIP	PHONE NO.
		( )

HAVE YOU BEEN TREATED BY OUR DOCTORS BEFORE? ☐ YES ☐ NO	DOES PATIENT RESIDE IN A NURSING HOME / SKILLED FACILITY? ☐ YES ☐ NO NAME ADDRESS

HOW WERE YOU REFERRED TO OUR OFFICE?	FAMILY DOCTOR (NAME AND PHONE NUMBER)
☐ FAMILY DOCTOR ☐ COACH/ATHLETIC TRAINER ☐ RADIO/BILLBOARD ☐ SOCIAL MEDIA ☐ FAMILY/FRIEND ☐ OTHER PHYSICIAN (PLEASE LIST) _____ ☐ GOOGLE SEARCH ☐ NEWSPAPER/MAILING _____	

DESCRIBE PROBLEM (INCLUDE PART OF BODY/SYMPTOMS)	PHARMACY NAME PHONE NO. ( )

INJURY INFORMATION

WAS THIS AN INJURY?	INJURY DATE	FOR ACCIDENT CLAIMS ☐ AUTOMOBILE ACCIDENT ☐ WORKER'S COMP ☐ OTHER _____

WERE X-RAYS TAKEN OF INJURY OR PROBLEM ☐ YES ☐ NO	WHERE WERE THEY TAKEN	DATE X-RAYS TAKEN

EXPLAIN HOW INJURY OR PROBLEM OCCURRED	LAWSUIT FILED ☐ YES ☐ NO

NAME OF CARRIER

POLICY HOLDER NAME	CLAIM NO.	NAME OF CLAIM REPRESENTATIVE/ATTORNEY	PHONE #
			( )

INSURANCE INFORMATION

PRIMARY	INSURANCE COMPANY/CARRIER	YES / NO PART A ☐ ☐ PART B ☐ ☐	POLICY HOLDER'S SOCIAL SECURITY NUMBER	
	POLICY HOLDER'S NAME		POLICY HOLDER'S BIRTHDATE	
	CONTRACT / ID NUMBER		GROUP	
	POLICY HOLDER'S RELATIONSHIP TO PATIENT		POLICY HOLDER'S EMPLOYER	
SECONDARY	INSURANCE COMPANY/CARRIER	YES / NO PART A ☐ ☐ PART B ☐ ☐	POLICY HOLDER'S SOCIAL SECURITY NUMBER	
	POLICY HOLDER'S NAME		POLICY HOLDER'S BIRTHDATE	
	CONTRACT / ID NUMBER		GROUP	
	POLICY HOLDER'S RELATIONSHIP TO PATIENT		POLICY HOLDER'S EMPLOYER	

The patient is responsible for payment of all services not covered by insurance. ALL CHARGES ARE DUE AT THE TIME OF SERVICE!
If surgery is indicated, the patient is responsible for furnishing insurance claim forms to the office PRIOR to surgery.

AUTHORIZATION TO DISCLOSE AND OR REQUEST MY PROTECTED HEALTH INFORMATION

(Please Read and Sign)

I authorize OrthoMichigan to furnish my protected health information to insurance carriers (including but not limited to the Center for Medicare and Medicaid) concerning my illness and treatment regarding related claims, in any form of media, whether electronic, paper, or oral. I hereby authorize OrthoMichigan to release my personal health information including my social security # to third parties for the collection of outstanding medical bills. I understand that I am responsible for all services not covered by my insurance. I permit a copy of this authorization to be used in place of the original and request that payment of medical insurance benefits be payable to OrthoMichigan. I also authorize the request for release of my medical records from any hospital or other facility at which I have been treated.

_____/_____/_____

Date Patient Signature (or Guardian) Relationship if other than patient