TESSON HEIGHTS ORTHOPAEDICS

Was this a work related injury? ________ if yes, do you have authorization for today's appointment? ________________________
If no, does your medical insurance require a referral?______________ If yes, did you receive it? ____________________________
Primary Care Physician:_________________________Referred By:____________________Date of Injury:___________________

PATIENT INFORMATION:

Last name First M.I. Date of Birth Age Sex

/_____/_____________________M____F___

Address City, State, Zip

Home Phone Work Phone Cell Phone SS# Marital Status

PATIENT'S EMPLOYER INFORMATION:

Employer

Telephone

SPOUSE'S EMPLOYER INFORMATION:

Employer of Spouse

Telephone

INSURANCE INFORMATION: PLEASE HAVE YOUR INSURANCE CARD AVAILABLE TO COPY

Primary Insurance Subscriber's Name Social Security# D.O.B.

ID # Group# Co-Pay Amount $

Secondary Insurance Subscriber's Name Social Security # D.O.B.

ID# Group# Co-Pay Amount $

IF WORK RELATED ACCIDENT, FILL OUT INFORMATION BELOW

Workmen's Comp Carrier Phone Fax Contact Name

Claim # Address City, State, Zip

CC:

Responsible Party Relationship Social Security # D.O.B

Address, City, State, Zip Phone #

IN CASE OF EMERGENCY, PLEASE CONTACT

Name:_________________________________Phone#_______________________Relationship to Patient____________________

Your signature confirms that all of the above information is correct and authorizes THO to correspond with the physicians listed above. I authorize the release of information to my insurance company, including Medicare; I also authorize insurance benefits to be paid directly to Tesson Heights Orthopaedics. I understand I am responsible for all deductibles and co-insurance, and non-covered services that may be required. In addition, I agree to pay for any additional charges related to the cost of collection in the event I fail to pay my bill. If signed by a guardian or parent, this is also an authorization for medical treatment of a minor. A photocopy of this document is to be considered as valid and original.

Patient Signature:____Date:_____________________________

THO/Sig Acct. # _______________ **MRI Acct. #**_________________ **THO Acct. #**_________________**Physician**________________