TOTAL ORTHOPEDIC CARE, INC
PATIENT DATA

ATTENTION: DOES YOUR INSURANCE REQUIRE THAT YOU GET A REFERRAL FROM YOUR PRIMARY CARE PHYSICIAN?
YES or NO IF YES, WE CANNOT SEE YOU WITHOUT A CURRENT REFERRAL.
IF YOU DO NOT GET A REFERRAL YOU WILL BE RESPONSIBLE FOR ANY BILLS.

TODAYS' DATE__________________ **BIRTHDATE**___________________ **AGE**_______________

NAME____

SEX: MALE/ FEMALE **RACE:** CAUCASION, AFRICAN AMERICAN, HISPANIC, AMERICAN INDIAN, ASIAN

MARITAL STATUS S M D W **SOCIAL SECURITY #**_______________________________________

EMAIL ADDRESS____

ADDRESS____

TOWN____**STATE**_____________ **ZIP**________________

MAILING____

TOWN____**STATE**_____________ **ZIP**________________

HOME PHONE_________________**WORK PHONE**___________________**CELL PHONE**__________________

PHARMACY NAME____**PHONE** __________________

PRIMARY PHYSICIAN NAME_______________________________________**PHONE**__________________

PCP ADDRESS____

OCCUPATION____ **BUISNESS PHONE**___________________

EMPLOYER____ADDRESS_________________________________

SPOUSE (PARENT OR GAURDIAN IF MINOR)____

PLEASE NOTE, ALL BILLS ARE THE PATIENT'S RESPONSIBILITY. PLEASE SUPPLY ALL INSURANCE INFORMATION BELOW. IF INCOMPLETE WE CANNOT BILL!!! WE WILL BILL YOUR INSURANCE ONCE AS A COURTESY TO YOU.

PRIMARY INSURANCE_______________________________________ ID #__________________________________

SUBSCRIBER NAME____________________________________ SUBSCRIBER DOB_________________________

SECONDARY INSURANCE____________________________________ ID #__________________________________

SUBSCRIBER NAME____

****IS INJURY WORK RELATED?**________**HAVE YOU REPORTED IT TO YOUR EMPLOYER**___________

****IS INJURY FROM AUTO ACCIDENT?**_______________

AUTHORIZATION TO RELEASE INFORMATION AND ASSIGNMENT OF BENEFITS

AUTHORIZATION FOR TREATMENT, TO PAY BENEFITS, RELEASE INFROMATION AND REFERRAL WAIVER:
I consent to being treated by Total Orthopedic Care which may include physical examination, x-rays, laboratory tests and other procedures necessary to diagnose and provide treatment. I fully understand that this or any other consent to my treatment may be withdrawn at my request. I authorize payment directly to the undersigned physician of the medical and/or surgical benefits. I hereby also authorize the undersigned physician to release any information acquired in the course of the examination or treatment necessary to process an insurance claim. I acknowledge receiving a copy of Total Orthopedic Care's Notice of Privacy Policy. I acknowledge that it is my responsibility to obtain a referral for specialty services from my Primary Care Physician prior ~~to~~ making an appointment & that I may be responsible for payment of services received should this be denied by my Primary Care Physician & my insurance company.

SIGNATURE____ DATE___________________________