

Southwest Center for Healthy Joints

Please complete this ENTIRE form and present your ID and Insurance Card(s)

HOW WERE YOU REFERRED TO US?

- Little Company of Mary Hosp, Christ Hospital, Little Company Care Station, Family / Friend, Primary Doctor > Name, Our Website, Noticed our Sign, Phone Book, On Line: Google, Dex / Yellow Pages

Patient: Address: City/State/Zip: Home Phone: Work Phone: Cell Phone: Email address:

Sex: M F Birth Date: Age: Social Security Number: (Person responsible for treatment authorization and financial responsibility)

Emergency Contact Name: Emergency Phone: Relationship to Patient: Self Parent Legal Guardian Care Taker Other:

Primary Care or Referring Physician:

IS YOUR VISIT DUE TO AN CAR ACCIDENT: YES NO Please ask front desk associate for the policy on Motor Vehicle Accidents (MVA).

IS THIS INJURY WORK RELATED? YES NO (If YES, WORKERS COMPENSATION visits require proof of claim by patient's employer before we can start treatment)

EMPLOYER INFORMATION

EMPLOYER (Policy Holder): Address: City/State/Zip: Phone:

PRIMARY INSURANCE CARRIER

Ins Co. Name: Plan Type: HMO PPO Work Comp Other: Insurance ID #: Group #: Subscriber DOB:

PRIMARY INSURANCE POLICY HOLDER INFORMATION

Name: Birth Date: SSN: Relationship to Patient: Self Parent Spouse Other:

SECONDARY INSURANCE INFORMATION

Ins Co. Name: Plan Type: HMO PPO Work Comp Other: Insurance ID #: Group #: Subscriber DOB:

SECONDARY INSURANCE POLICY HOLDER INFORMATION

Name: Birth Date: SSN: Relationship to Patient: Self Parent Spouse Other:

I authorize the release of all medical information necessary to process my insurance claim. I assign all medical and/or surgical benefits including major medical benefits to which I am entitled to Southwest Orthopedics (DBA Southwest Center for Healthy Joints). I understand that regardless of my insurance, I am financially responsible for the fees, services rendered, all collection and attorney fees, if applicable. A digital copy of this assignment is considered valid as the original. This assignment will remain in effect until revoked by my in writing.

Patient / Legal Guardian: Date: