PATIENT INFORMATION (ADULT)

Patient's Name:____ DOB:_______________ Todays date:________________

Address:____ Age:______ Gender:________

City:_______________________________ State:________ Zip:__________ Home Phone:_____________________________

SSN:______________________ Driver's Lic:__________________ Cell Phone:_____________________________________

Patient Employer:_____________________________________ Occupation:____

Business Address:____ Business Phone:______________________

City:______________________ State:_____ Zip:________ Email:____

Spouse's Name:______________________________ Phone:_____________ Spouse's Employer:_________________________

Name of Referring Physician/Therapist/Trainer:_____________________________________

Name of Primary Care Physician:____

Emergency Contact:______________________________Relationship:__________________Phone:_______________________

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Were you injured at work? (circle one) Yes No

Was the injury a result of an accident!? (circle one) Yes No

Was an autombile involved? (circle one) Yes No

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INSURANCE INFORMATION **Person responsible for the payment?**

□ Self **□ Spouse** **□ Parent** **□ Cash** **□ Auto** **□ Legal** **□ Worker's Comp**

In addition to your insurance card this information must be fully completed in order for us to courtesy bill your insurance company.

PRIMARY Insurance Co: ______________________________________ Name of Insured:________________________________

Insured Employer:______________________ Insured DOB:_______________Relationship to self:________________________

Insured SSN:_____________________________ Group#:_____________________ ID#:________________________________

SECONDARY Insurance Co:____________________________________ Name of Insured:_________________________________

Insured Employer:________________________ Insured DOB:_________________ Relationship to self:_____________________

Insured SSN:_____________________________ Group#:_______________________ ID#:________________________________

If you checked "legal" above, please provide your attorney's name:____

Address:____ Phone:_______________________________

******************************AUTHORIZATION TO RELEASE INFORMATION AND ASSIGNMENT OF BENEFITS****************************

If your check is returned by the bank, a $20 service charge will be added to your account. I request that payment of authorized Medicare/ Other insurance company benefits be made to Beach Cities Orthopedics and Sports Medicine for any services to me by the physician who accepts assignment. Regulations pertaining to Medicare apply. I authorize any holder of medical, or other information about me to release the Social Security Administration and Health Care Financing Administration or its intermediaries or carriers of any information needed for this or related Medicare/ Other Insurance Company claim. I permit a copy of this authorization to be used in place of the original. I understand that it is mandatory to notify the healthcare provider or any other party who may be responsible for paying for my treatment. (Section1128B of the social Security Act and 31U.S.C. 381-3812 provides penalties for witholding this information). Conditional payment of any charges resulting from 3rd party liability will be requested from the insurance company. At the time of settlement of 3rd party liability cases,insured will be responsible for reimbursing the insurance company payments made and the payment in full for any medical charges incurred in this office relating to said inquiry. I understand that payment is my obligation and responsibility, regardless of insurance and other third party involvement. I have read and understand possible finacial responsibility for services rendered and hearby affix signature as ackknowledgement of this understanding.

____ ______________________________________

Signature of Patient Date