

**ORTHOPAEDIC SPECIALTY GROUP, P.C.**  
**PATIENT INFORMATION RECORD**  
(PLEASE PRINT OR WRITE LEGIBLY)

<b>PATIENT INFORMATION</b>				Appt With: _____	
Acct #: _____				Today's Date: _____	
Patient's Name		Male/Female	Marital Status	Date of Birth	
		S   M   W   Div   Sep			
Street Address		City & State		Zip Code	Home Phone #
Patient's Employer			Occupation (Indicate if student)		Business Phone #
Employer's Street Address			City & State		Zip Code
Who Referred You To This Practice?				Family Doctor	
<b>EMERGENCY CONTACT</b>					
Name			Relationship		Telephone #
<b>PRIMARY HEALTH INSURANCE</b>					
Insurance Company			ID or Member#		Group #
Insured's Name		Relationship to Patient		Insured's Date of Birth	Insured's Social Security #
Insured's Address (if different than patient's)			City & State		Zip Code
Insured's Employer			Employer's Telephone #		
Street Address		City & State			Zip Code
<b>SECONDARY HEALTH INSURANCE</b>					
Insurance Company			ID or Member#		Group #
Insured's Name		Relationship to Patient		Insured's Date of Birth	Insured's Social Security #
Insured's Address (if different than patient's)			City & State		Zip Code
Insured's Employer			Employer's Telephone #		
Street Address		City & State			Zip Code

**WORKER'S COMPENSATION \_\_\_ YES \_\_\_ NO NO-FAULT AUTO ACCIDENT \_\_\_ YES \_\_\_ NO**  
**If yes to either question, please complete additional sheet.**

I hereby authorize the above physician to release any medical information necessary to process this claim. In addition, I hereby authorize direct payment of insurance to this provider. I understand that I am financially responsible for all charges for services rendered to me, including any balance remaining after payment of insurance benefits. In the event that my account is turned over for third party collections, I will be responsible for all charges up to the statutory limits.

\_\_\_\_\_  
(Patient, or Legal Guardian)

\_\_\_\_\_  
Date