

# Orthopedics Northwest

Doctor: \_\_\_\_\_

## PATIENT INFORMATION

Name: _____	Patient ID #: _____	Sex: <input type="checkbox"/> M <input type="checkbox"/> F
Address: _____	Date of Birth: _____	
City, State, Zip: _____	Social Security #: _____	
Phone: _____ <input type="checkbox"/> Home <input type="checkbox"/> Work <input type="checkbox"/> Other	Marital Status: <input type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Other	
Phone: _____ <input type="checkbox"/> Home <input type="checkbox"/> Work <input type="checkbox"/> Other	Referring Physician: _____	
	Primary Physician: _____	

## PATIENT'S EMPLOYMENT INFORMATION

Employed  Retired  Other

Phone: \_\_\_\_\_

Employer: \_\_\_\_\_

## EMERGENCY CONTACTS

	Name	Relationship	Phone
1.	_____	_____	_____
2.	_____	_____	_____

## GUARANTOR INFORMATION

Same as Patient

Name: \_\_\_\_\_

Address: \_\_\_\_\_

City, State, & Zip: \_\_\_\_\_

Employer: \_\_\_\_\_

Phone: \_\_\_\_\_

Phone 2: \_\_\_\_\_

SSN: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

## PRIMARY INSURANCE INFORMATION

Same as Patient  Same as Guarantor  Other

Insured Party Name: \_\_\_\_\_

Insured Phone: \_\_\_\_\_

Insured's Employer: \_\_\_\_\_

Insurance Company: \_\_\_\_\_

Insured ID: \_\_\_\_\_

Social Security #: \_\_\_\_\_

Insured's Date of Birth: \_\_\_\_\_

Policy Group: \_\_\_\_\_

Patient's Relationship to Insured: \_\_\_\_\_

## SECONDARY INSURANCE INFORMATION

Same as Patient  Same as Guarantor  Other

Insured Party Name: \_\_\_\_\_

Insured Phone: \_\_\_\_\_

Insured's Employer: \_\_\_\_\_

Insurance Company: \_\_\_\_\_

Insured ID: \_\_\_\_\_

Social Security #: \_\_\_\_\_

Insured's Date of Birth: \_\_\_\_\_

Policy Group: \_\_\_\_\_

Patient's Relationship to Insured: \_\_\_\_\_

## Accident Related Injury (Work, Auto, Other) Circle one. Must be completed if injury is related to work or auto accident.

Insurance Company Name: \_\_\_\_\_ Claim Number: \_\_\_\_\_

Address: \_\_\_\_\_ Phone: \_\_\_\_\_

City, State, & Zip: \_\_\_\_\_ Employer @ \_\_\_\_\_

Date of Injury: \_\_\_\_\_ Body Part: \_\_\_\_\_ time of Injury: \_\_\_\_\_

## **INSURANCE AUTHORIZATION AND ASSIGNMENT**

(Please read and sign)

I attest that the information I have given here is correct and true to the best of my knowledge. I hereby assign benefits to Orthopedics Northwest, LLP, and authorize them to furnish information regarding my treatment to my insurance company. I understand that my contract with my insurance company requires me to be compliant to the rules of my policy regarding referrals to medical specialists.

***I understand that I am responsible for any amount not paid for by my insurance.***

\_\_\_\_\_  
PATIENT / RESPONSIBLE PARTY SIGNATURE

\_\_\_\_\_  
DATE