



COME TO SEVEN SPRINGS ORTHOPAEDICS & SPORTS MEDICINE

For office use only: Account #

Provider:

Date:

PATIENT INFORMATION

Full Name: (First)			(Middle)	(Last)		
Home Address:						
City:		State:		Zip Code:		
Home Phone ()		SS # - -		<input type="checkbox"/> M <input type="checkbox"/> F		Birth Date: / /
Age:		Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed Spouse's Name:				
Patient's Employer:				Work Phone: ()		
Employer's Address:						
Occupation:		E-mail Address:		Cell Phone: ()		

RESPONSIBLE PARTY (BILL TO) INFORMATION

--- Complete this section **ONLY** if someone **other** than the patient is financially responsible. ---

Responsible Party: (First)			(Middle)	(Last)			<input type="checkbox"/> M <input type="checkbox"/> F
Address:							
City:		State:		Zip Code:			
Home Phone: ()		Work Phone: ()		Cell Phone: ()			
Social Security #: - -		Relationship to Patient:		Birth Date: / /			
Name of Employer:							

EMERGENCY CONTACT INFORMATION

Name:			Relationship:			
Home Phone: ()		Work Phone: ()		Cell Phone: ()		

REFERRAL INFORMATION

Who referred you to our office?			Who is your Family Physician?			
---------------------------------	--	--	-------------------------------	--	--	--

INSURANCE INFORMATION

Primary Insurance Co:		Group #:		Policy #:		
Name of Insured:		SS # - -		Birth Date / /		Relationship to Patient:
Secondary Insurance Co:		Group #:		Policy #:		
Name of Insured:		SS # - -		Birth Date / /		Relationship to Patient:

If you have an HMO insurance plan, did you contact your Primary Care Physician (PCP) for a referral? Yes No

Our office will file insurance for all reimbursable services to both your primary and secondary insurance carriers. Please remember that you are responsible for all deductible, co-pay, and non-covered service amounts for the date of service you are seen. By signing this form, I agree to be responsible for any legal fees and/or fees incurred in the collection of charges for this account. I authorize the release of any medical information necessary to process my claim(s). I authorize payment(s) of medical and surgical benefits to Seven Springs Orthopaedics & Sports Medicine.

Signature of Patient or Responsible Party

Today's Date