

DOCTOR: \_\_\_\_\_

PATIENT ACCT # \_\_\_\_\_

**PATIENT INFORMATION FOR MEDICAL RECORDS – PLEASE PRINT**

Last Name \_\_\_\_\_ First Name \_\_\_\_\_ M \_\_\_\_\_

Home Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Daytime Phone ( ) \_\_\_\_\_ Evening Phone ( ) \_\_\_\_\_

Work Phone ( ) \_\_\_\_\_ Cell Phone ( ) \_\_\_\_\_

Sex M F Marital Status S M Birth Date \_\_\_\_/\_\_\_\_/\_\_\_\_

Social Security Number \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Age \_\_\_\_\_

Patient's Employer \_\_\_\_\_ Occupation \_\_\_\_\_

Referred by Whom \_\_\_\_\_ Family Physician \_\_\_\_\_

In case of Emergency Contact \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

Home Phone ( ) \_\_\_\_\_ Work Phone ( ) \_\_\_\_\_

**IF PATIENT IS A MINOR, PLEASE COMPLETE USING PARENT INFORMATION:**

Father's Name \_\_\_\_\_ Employer \_\_\_\_\_

Work Phone ( ) \_\_\_\_\_ Social Security Number \_\_\_\_\_

Mother's Name \_\_\_\_\_ Employer \_\_\_\_\_

Work Phone ( ) \_\_\_\_\_ Social Security Number \_\_\_\_\_

**INSURANCE INFORMATION**

**IS THIS A WORK RELATED INJURY? YES NO**

**PRIMARY INSURANCE**

**SECONDARY INSURANCE**

Insurance Co \_\_\_\_\_

Insurance Co \_\_\_\_\_

If HMO which IPA: Seaview Valley Care Ojai Valley BVMG

If HMO which IPA: Seaview Valley Care Ojai Valley BVMG

Subscriber # \_\_\_\_\_

Subscriber # \_\_\_\_\_

Group # \_\_\_\_\_

Group # \_\_\_\_\_

Subscriber \_\_\_\_\_ DOB: \_\_\_\_\_

Subscriber \_\_\_\_\_ DOB: \_\_\_\_\_

Subscribers Relationship to Patient \_\_\_\_\_

Subscriber's Relationship to Patient \_\_\_\_\_

Co-payment \$ \_\_\_\_\_

Co-payment \$ \_\_\_\_\_

**CO-PAYMENTS ARE DUE AT THE TIME OF SERVICE.**

**AUTORIZATION FOR MEDICAL TREATMENT, RELEASE OF MEDICAL INFORMATION AND FINANCIAL AGREEMENT.**

I/WE DIRECTLY ASSIGN ALL MEDICAL/SURGICAL BENEFITS TO THE ORTHOPEDIC SURGEON AND UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES WHETHER OR NOT PAID BY INSURANCE. I HEREBY AUTHORIZE THE ORTHOPEDIC SURGEON TO RELEASE ALL INFORMATION NECESSARY TO SECURE THE PAYMENT OF BENEFITS.

\_\_\_\_\_  
Patient Signature or Legal Guardian

\_\_\_\_\_  
Print Name

\_\_\_\_\_  
Date