SEA VIEW ORTHOPAEDIC MEDICAL GROUP

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PLEASE FILL IN BELOW

LAST NAME **FIRST NAME** **DOB** **AGE**

PHONE # **DRIVERS LIC #** **WHO REFERRED YOU**

ADDRESS **APT #** **CITY** **STATE** **ZIP CODE**

SOCIAL SECURITY # **SEX (M/F)** **MARITAL STATUS** **EMAIL**

EMPLOYER **OCCUPATION** **EMPLOYER PHONE #**

EMPLOYER ADDRESS **CITY** **STATE** **ZIP CODE**

IS YOUR CONDITION WORK RELATED (Y/N) **DATE OF INJURY** **REPORTED TO YOUR EMPLOYER (Y/N)**

WHO IS YOUR INTERNIST/PRIMARY CARE PHYSICIAN/PEDIATRICIAN? **DRUG OR FOOD ALLERGY**

IF THE PATIENT IS A MINOR, PLEASE GIVE US YOUR INFORMATION BELOW:

LAST NAME FIRST NAME DOB AGE

PHONE # DRIVERS LIC # WHO SENT YOU HERE

ADDRESS APT # CITY STATE ZIP CODE

SOCIAL SECURITY # SEX (M/F) MARITAL STATUS DRUG OR FOOD ALLERGY

PRIMARY INSURANCE INFORMATION ☐ CHECK BOX IF INS CARD AND ID WERE PROVIDED

INSURANCE NAME AND ADDRESS

SUBSCRIBER ID# GROUP # COVERAGE DATE (FROM/TO)

PROVIDER PHONE # AUTHORIZATION PHONE # (IF APPLICABLE)

NAME PRIMARY INSURED PRIMARY INSURED DOB PRIMARY INSURED SSN

INSURED EMPLOYER ADDRESS PHONE #

EMERGENCY CONTACT: NAME: **RELATIONSHIP:**

PHONE NUMBER:

Our office will bill your insurance. You are responsible for the deductible, share of cost, co-payment, and any costs not a benefit of your plan at the time of the visit. If you do not have insurance, we expect payment at the time of your visit. Our staff is available if you have any questions. I authorize payment of medical benefits be made directly to the rendering physician for services provided. I authorize my physician to release any medical or other information necessary to process claims with my insurance company(ies). I request payment of any government benefits to the party who accepts assignment. I authorize use of information from this form to bill my insurance company(ies).

PATIENT (AUTHORIZED REPRESENTATIVE) SIGNATURE DATE