

PATIENT INFORMATION FORM

Print the form below, fill it out and bring it to the office along with your insurance card(s).

Last Name: _____ Sex: Male Female Date of Birth: _____

First Name: _____ Marital Status: S M W D Social Security#: _____

Home Address: _____ Home Phone: _____

City: _____ State: _____ Zip: _____ Cell Phone: _____

Employer: _____ Work Phone: _____

Referred by (Attorney / Adjuster / Friend / School / Other): _____

Primary Care Physician: _____ Phone: _____

Address: _____ City: _____ State: _____

Part of Body Injured _____ **Date of Onset:** _____

Is injury /condition related to: Work / School / Auto Accident / Other: _____

Do you have an attorney for this injury? Yes No

If Yes, do you authorize this office to submit medical and billing information to your attorney: YES NO

Name of Attorney: _____

Address: _____ City: _____ State: _____ Phone: _____

EMERGENCY CONTACT

Name / Relationship and Phone _____

MEDICAL INSURANCE INFORMATION

Insurance Co: _____ Policyholder's Name: _____

Policyholder's SS#: _____ Policyholder's Relationship to Patient: Spouse Parent Other

Policyholder's Date of Birth: _____ Employer: _____

Ins. Co. Address: _____ Phone: _____

ID# _____ Group/Policy # _____ Referral Required: Yes No

Secondary Insurance

Insurance Co: _____ Policyholder's Name: _____

Policyholder's SS#: _____ Policyholder's Relationship to Patient: Spouse Parent Other

Policyholder's Date of Birth: _____ Employer: _____

Ins. Co. Address: _____ Phone: _____

ID# _____ Group/Policy # _____ Referral Required: Yes No

I CONSENT TO MEDICAL TREATMENT BY FRANK FEMINO MD AND STEPHEN DUCEY MD AND I HEREBY AUTHORIZE FEMINO-DUCEY ORTHOPAEDIC GROUP TO FURNISH INFORMATION TO INSURANCE CARRIERS CONCERNING MY ILLNESS AND TREATMENT. I HEREBY ASSIGN TO FEMINO-DUCEY ORTHOPAEDIC GROUP ALL PAYMENT FOR MEDICAL AND OR SURGICAL SERVICES RENDERED TO MYSELF OR MY DEPENDENTS. I UNDERSTAND THAT I AM RESPONSIBLE FOR ANY AMOUNT NOT COVERED BY INSURANCE. I AGREE TO PAY ALL COSTS OF COLLECTION, INCLUDING A REASONABLE ATTORNEY'S FEE, SHOULD THIS ACCOUNT BE PLACED WITH AN ATTORNEY FOR COLLECTION.

Signature: _____

Date: _____