Precision Orthopaedics – Patient Demographics

Patient's Name: _____ DOB: _____/_____/_____

Street Address: _____

City: _____ State: _____ ZIP: _____

Phone #: _____ Secondary #: _____

SS#: _____ Male: _____ Female: _____

E-mail Address: _____

Preferred Pharmacy: _____ Phone: _____
(Name & City)

Primary Care Physician: _____ Ph: _____

Referred By: (Please check one) _____ Primary Care Physician _____ Friend/ Family _____

Cardiologist (if applicable): _____ Ph: _____

Insurance: _____
(Please provide us with your insurance card for ID#, Group #, and Billing Address)

Patient's Employer Info:

Employer: _____

Occupation: _____

Work Phone: _____

Spouse's Employer Info:

Employer: _____

Work Phone: _____

Is this appointment due to a work-related injury? _____ Yes _____ No

In Case of Emergency, Please Contact:

Name: _____ Relationship: _____ Phone: _____

Your signature confirms that all of the above information is correct and authorizes Precision Orthopaedics to correspond with the physician listed above. I authorize the release of information to my insurance company, including Medicare. I also authorize insurance benefits to be paid directly to Precision Orthopaedics, a division of Anderson Medical Group. I understand that I am responsible for all deductibles and co-insurances, and non-covered services that may be required. In addition, I agree to pay any additional charges related to the cost of collection in the event I fail to pay my bill. If signed by a parent or guardian, this is also an authorization for medical treatment of a minor. A photocopy of this document is to be considered as valid and original.

Patient/Parent/Guardian Signature: _____ Date: _____