PATIENT INFORMATION SHEET

NAME____ DATE OF BIRTH___/___/___ GENDER____________________

ADDRESS_______________________________________ DAYTIME NUMBER___________________________________

CITY/STATE/ZIP__________________________________ EVENING NUMBER___________________________________

E-MAIL ADDRESS____________________________________

MARITAL STATUS________________________________ IS PATIENT EMPLOYED? YES or NO

WORK RELATED INJURY? YES or NO EMPLOYER NAME____________________________________

DATE OF INJURY________________________________ CITY/STATE/ZIP______________________________________

OCCUPATION___________________________________ EMPLOYER PHONE #_________________________________

IF PATIENT IS A STUDENT, IS IT? FULL-TIME or PART-TIME NAME OF SCHOOL___________________________________

RACE (Circle one): Caucasian Black Asian Hispanic Native Hawaiian American Indian Middle Eastern Multiracial

ETHNICITY (Circle one): Hispanic Non-Hispanic LANGUAGE____

PHARMACY______________________________________ LOCATION/PHONE#__________________________________

INSURED INFORMATION

INSURED RELATIONSHIP TO THE PATIENT (Circle one): SELF SPOUSE PARENT OTHER

NAME OF POLICY HOLDER__________________________ DATE OF BIRTH___/___/___ GENDER______________

ADDRESS____ TELEPHONE #_______________________________________

CITY/STATE/ZIP___________________________________

EMPLOYER NAME_________________________________ EMPLOYER PHONE NUMBER___________________________

EMPLOYER ADDRESS____

INSURANCE CARRIER INFORMATION

PRIMARY CARRIER_________________________________ ID/SUBSCRIBER #____________________________________

ADDRESS____ GROUP #____

CITY/STATE/ZIP____

SECONDARY CARRIER______________________________ ID/SUBSCRIBER #____________________________________

ADDRESS____ GROUP #____

CITY/STATE/ZIP____

NAME OF PRIMARY CARE PHYSICIAN____

NAME OF REFERRING PHYSICIAN (IF ANY)____

Assignment of Benefits: I hereby assign all medical and/or surgical benefits, including major medical benefits to which I am entitled, private insurance and any other health plan payments to The Orthopedic Institute of Wisconsin. This assignment shall remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges whether or not they are paid for by aforementioned insurance carrier(s). I hereby authorize said assignee to release all information necessary in order to secure payment. I understand that I am responsible for updating the above information, in a timely fashion, should there be any changes.

PATIENT SIGNATURE ____ **DATE**_________________________________