ORTHOPEDIC SURGERY SPECIALISTS, PLLC

TODAY'S DATE: _____ **INJURY DATE:** _____ **SURGERY DATE:** _____

PATIENT NAME: _____

DATE OF BIRTH: _____ **SS#:** _____

EMAIL: _____ (for appointment reminders)

PHONE: _____☐CELL☐HOME **ALT PHONE:** _____ ☐CELL☐HOME

MAILING ADDRESS: _____

CITY: _____ **STATE:** _____ **ZIP:** _____

EMERGENCY CONTACT: _____ **PHONE:** _____

RACE: ☐American Indian / Alaska Native ☐Asian ☐Black/African American ☐White
LANGUAGE: ☐English ☐French ☐German ☐Japanese ☐Mandarin ☐Russian ☐Spanish
ETHNICITY: ☐Hispanic ☐Non-Hispanic
DOMINANT HAND: ☐Left ☐Right ☐Both

EMPLOYMENT STATUS: ☐Employed ☐Unemployed ☐Retired ☐Disabled ☐Student

EMPLOYER'S NAME & ADDRESS: _____

_____

MARITAL STATUS: ☐Married ☐Single ☐Divorced ☐Widowed

NAME OF GUARANTOR FOR ACCOUNT: _____

☐Same as above (patient)

ADDRESS OF GUARANTOR: _____

☐ Same as above (patient)

PRIMARY INSURANCE: _____

CONTRACT # _____ GROUP # _____

SUBSCRIBER NAME: _____ SUBSCRIBER DOB:_____

SECONDARY INSURANCE: _____

CONTRACT # _____ GROUP # _____

SUBSCRIBER NAME: _____SUBSCRIBER DOB:_____

PRIMARY CARE PHYSICIAN: _____

PHONE: _____ **FAX:** _____

REFERRRING PHYSICIAN: _____

PHONE: _____ **FAX:** _____

PHARMACY NAME: _____

CITY OR CROSSROADS: _____

PHONE: _____ **FAX:** _____

Is this an auto injury? ☐YES ◙NO

If Yes, date of accident or injury? _____ Claim# _____

Insurance Company?_____ Adjuster Name: _____

Adjuster Phone: _____ Adjuster Fax: _____

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Is this a Worker's Comp Injury? ☐YES ◙NO

If Yes, date of accident or injury? _____ Claim# _____

Insurance Company?_____ Adjuster Name: _____

Adjuster Phone: _____ Adjuster Fax: _____

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Do you have a legal claim pending in relation to your injury? ☐YES ◙NO

Attorney's Name: _____

Attorney's Phone: _____ Attorney's Fax: _____