

EASTERN OREGON ORTHOPAEDIC SURGERY & FRACTURE CLINIC, INC.

PATIENT INFORMATION		Who were you referred by	Physical Area to be Treated	Date	
Patient's Name (Last)	(First)	(Middle)	(Maiden Name)	Birth Date	Age
Home Address	Street/P.O. Box	City	State	Zip	
Marital Status <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Single <input type="checkbox"/> Widowed	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	Social Security Number	Home Phone	Work Phone	
Name of Employer			Occupation		
Employer's Address	Street/P.O. Box	City	State	Zip	

RESPONSIBLE PARTY INFORMATION		If same as above, please check this box <input type="checkbox"/>	Patient Relationship to Responsible Party <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Son <input type="checkbox"/> Daughter <input type="checkbox"/> Other _____		
Responsible Party Name (Last)	(First)	(Middle)	(D.O.B.)	Responsible Party Home Phone	
Responsible Party Address	Street/P.O. Box	City	State	Zip	Responsible Party Social Sec. Number
Responsible Party Employer			Occupation	Responsible Party Work Phone	
Responsible Party Employer Address	Street/P.O. Box	City	State	Zip	

PERSON TO CONTACT IF UNABLE TO REACH YOU DIRECTLY - NAME OF FRIEND OR RELATIVE (NOT LIVING WITH YOU)					
Name		<input type="checkbox"/> Son <input type="checkbox"/> Daughter <input type="checkbox"/> Friend <input type="checkbox"/> Other _____			Home Phone
Address	Street/P.O. Box	City	State	Zip	

INSURANCE INFORMATION		Date of Injury	What Happened (brief description)		
Primary Insurance	Name of Policyholder	Group No.	Contract No./I.D. No.	Birth Date	
Place of Employment	Description		Work Phone		
Relation to Patient	Insurance Address				
Secondary Insurance	Name of Policyholder	Group No.	Contract No./I.D. No.	Birth Date	
Place of Employment	Description		Work Phone		
Relation to Patient	Insurance Address				

ACCIDENT INFORMATION		Were you injured in an auto accident ? <input type="checkbox"/> Yes <input type="checkbox"/> No	Were you injured at work ? <input type="checkbox"/> Yes <input type="checkbox"/> No	Other Accident <input type="checkbox"/> Yes <input type="checkbox"/> No	Accident of Injury Date
Insurance	Name of PolicyHolder	Policy No. or Workman's Compensation Claim No.			
Address	Street/P.O. Box	City	State	Zip	
If work related, list employer name at time of injury			Employer Workman's Comp. Contact/Phone Number		

ASSIGNMENT OF BENEFITS / CONSENT FOR TREATMENT:

I hereby authorize that payment of the amount due me in my pending insurance claim be made directly to: Eastern Oregon Orthopaedic Surgery & Fracture Clinic, Inc. Payment is authorized upon your receipt of an itemized statement of the services. I acknowledge that I am financially responsible for all charges whether or not paid by insurance. If it becomes necessary to effect collections of amount, the undersigned agrees to pay for all costs and expenses, including reasonable attorney fees.

I hereby authorize Eastern Oregon Orthopaedic Surgery & Fracture Clinic., Inc., to release to my referring physician, insurance company, or legal guardian, any information including diagnosis and records of treatment, concerning my past medical history and orthopaedic care. I give consent for treatment by my signature below.

Signed: X _____ Date _____