VALLEY ORTHOPEDIC INSTITUTE

PLEASE PRINT CLEARLY AND COMPLETELY

PATIENTS NAME —LAST: **FIRST:** **MI:**

ADDRESS: **CITY:**

ZIP CODE: **STATE:** **D.O.B.** **MARITAL STAUS:**

SEX: **SSN:** **DRIVERS LICENSE #**

OCCUPATION: **EMPLOYER:**

EMPLOYERS ADDRESS:

HOME PHONE: ( ) **CELL PHONE: ( )**

WORK PHONE: ( ) **EMAIL:**

PRIMARY CARE PHYSICAN: **PHONE: ( )**

EMERGENCY CONTACT: **PHONE: ( )**

INSURANCE INFORMATION

PRIMARY INSURANCE NAME: **MEMBER NUMBER:**

SUBSCRIBER NAME: **SUBSCRIBER D.O.B.**

EMPLOYER: **WK PH #( )**

SECONDARY INSURANCE NAME: **MEMBER NUMBER:**

SUBSCRIBER NAME: **SUBSCRIBER D.O.B.**

IS THIS A WORK RELATED OR PERSONAL INJURYCASE: YES / NO _____

I acknowledge full responsibility for the payment of services rendered to me and agree to pay for services not covered by my insurance carrier. I understand it is my responsibility to pay any deductible amount, co-payment, co-insurance or any other balance not paid for by my insurance. I understand and agree that the health insurance policies are an arrangement between the insurance carrier and myself. I authorize payment for all medical/surgical benefits to be made to the physicians for medical services rendered. A photocopy of this signature is valid as the original. I also authorize the physicians to release any medical information about me, should my insurance carrier request additional information. I understand and agree that if I fail to cancel or re-schedule any future appointments within 24-hrs of the scheduled appointment time and date I will be charged a $25 fee.

SIGNATURE OF PATIENT: _____ **DATE:** _____

(SIGNATURE OF LEGAL GUARDIAN IF PATIENT IS A MINOR)