

Patient Information



**GREENSBORO
ORTHOPAEDICS**
DOCTORS FOR AN ACTIVE LIFE

Use Black Ink Only!

Account #:		Doctor:
Patient Last Name	First Name	Middle/Maiden Name
Patient Address Street	City	State Zip
Patient Home Phone #	Patient Work Phone #	Employer:
(Please Circle) Male Female	Date of Birth:	Social Security #:
(Patient Under 18)		
Responsible Party's Last Name	First Name	Middle/Maiden Name
Responsible Party's Address Street	City	State Zip
Responsible Party's Home Phone#	Responsible Party's Work Phone #	E-mail address:
(Please Circle) Male Female	Date of Birth:	Social Security #:
Medicare Patients Only Was this a liability injury? (Please Circle) Yes No If yes, please ask receptionist for additional form.		
Were you hurt at work? (Please Circle) Yes No If yes, have you notified your employer? Yes No Did your employer file an injury report with their Workers' comp. carrier? Yes No Who is the person to contact at your employer? Name: Phone#:		
Primary Insurance:	Policy Holder's Name:	
Policy Holder's SS#:	Policy Holder's Date of Birth:	
How is the patient related to Policy Holder? (Please Circle) Self Husband Wife Male Child Female Child		Effective Date:
Policy Holder's Employer:		Employer's Phone#:
Secondary Insurance:	Policy Holder's Name:	
Policy Holder's SS#:	Policy Holder's Date of Birth:	
How is the patient related to Policy Holder? (Please Circle) Self Husband Wife Male Child Female Child		Effective Date:
Policy Holder's Employer:		Employer's Phone#:
Preferred Pharmacy Name & Location:	Pharmacy Phone#:	
Spouse's Name:	Day time Phone#:	
Emergency contact (Not living with you)	Day time Phone#:	Home Phone#:
Marital Status? (Please Circle) Single Married Separated Widower Widow		Known Allergies:
Referred by (Please Circle) Another Doctor: _____ Friend/Family TV Radio ER Cone ER Wesley Long Yellow Pages Newspaper Insurance Company Employer Other:		

Acceptance of Financial Responsibility: I understand that I am responsible for all medical expenses regardless of insurance coverage and whether or not there is an accident with another person at fault. Also, if this is a work related injury and the Workers' Compensation carrier denies payment, I understand I am responsible for these charges.

Authorization to Release Information: I hereby request and authorize Greensboro Orthopaedic Center to release any and all information regarding my examination, care and treatment, including, but not limited to, information concerning my age, date of birth, address, social security number, employer and medical insurance, and to furnish copies of all medical reports, x-rays, laboratory tests, etc., containing this information and/or concerning my condition unless revoked in writing by me.

Authorization to Pay: I hereby authorize payment to Greensboro Orthopaedic Center of any surgical and/or medical benefits. I have completed this form fully and completely and certify this information is true and correct to the best of my knowledge.

SIGNATURE (PATIENT, PARENT OR RESPONSIBLE PARTY)

DATE