

# BLAIR ORTHOPEDICS

## PATIENT INFORMATION

Date of Appointment \_\_\_\_\_

Patient Name _____ Address _____ City, State _____ Zip Code _____ Area Code/Phone No. _____ Referring Physician _____ Social Security No. _____ Height _____ Weight _____	E-mail address _____ Date of Birth _____ Marital Status _____ Patient Sex (Male / Female) _____ Work Status (Part/Full) _____ Student Status (Part/Full/ NA) _____ Date last worked _____ Patient Employer _____ Employer Address, City, State _____ Employer Zip Code _____ Employer Phone _____
--	---

**GUARANTOR INFORMATION** \*\* If patient is **under the age of 18** the parent or legal guardian that is accompanying the patient today will need to provide their guarantor information below.

Guarantor Information Same As Above/patient is 18 years or older <input type="checkbox"/> (please check box)	
Patient's Relationship to Guarantor _____ Guarantor Name _____ Address _____ City, State, Zip Code _____ Guarantor Area Code/Phone No. _____	Guarantor Employer _____ Address _____ Phone _____ Guarantor Social Security No. _____ Guarantor Birthdate _____ Sex _____

## INSURANCE INFORMATION

<b>Primary</b> Name of Insurance Co. _____ Address of Insurance Co. _____ Name of Policy Holder _____ Relationship to Patient _____ Employer of Policy Holder _____ Policy Holder Address _____ Policy Holder City, State & Zip Code _____ Social Security No. _____ Policy Holder Area Code/Phone No. _____ Policy Holder DOB _____ Policy Holder Sex _____ Policy Number _____ Group Number _____ Effective Dates _____ Secondary Number _____ Group Number _____ Effective Dates _____		
<b>Secondary</b> Name of Insurance Co. _____ Address of Insurance Co. _____ Name of Policy Holder _____ Relationship to Patient _____ Employer of Policy Holder _____ Policy Holder Address _____ Policy Holder City, State & Zip Code _____ Social Security No. _____ Policy Holder Area Code/Phone No. _____ Policy Holder DOB _____ Policy Holder Sex _____ Policy Number _____ Group Number _____ Effective Dates _____ Secondary Number _____ Group Number _____ Effective Dates _____		

Is this an Auto Accident? \_\_\_\_\_ or Liability? \_\_\_\_\_ Is this a Workman's Compensation Case? \_\_\_\_\_  
If yes, date of injury \_\_\_\_\_ and what body part injured? \_\_\_\_\_ Was employer notified? \_\_\_\_\_

**ASSIGNMENT OF BENEFITS:** I hereby assign all medical and/or surgical benefits to which I am entitled including major medical, Medicare, private insurance and any other health plans to **Blair Orthopedics**. This agreement will 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 paid by said insurance. I hereby authorize said assignee to release all information necessary to secure the payment.

Signed \_\_\_\_\_ Date \_\_\_\_\_

**\*\* PAYMENT IS EXPECTED AT THE TIME SERVICES ARE RENDERED \*\***

I have received, read and understand Blair Orthopedics' Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that Blair Orthopedics has the right to change its Notice of Privacy Practices from time to time and that I may contact Blair Orthopedics at any time to obtain a current copy of the Notice of Privacy Practices. A copy of our Notice of Privacy Practices will be posted on our website at [www.blairortho.com](http://www.blairortho.com)

Signed \_\_\_\_\_ Date \_\_\_\_\_

**OFFICE USE ONLY** I attempted to obtain the patient's signature in acknowledgement of the Notice of Privacy Practices, but was unable to do so as documented below:

Date \_\_\_\_\_ Initials \_\_\_\_\_ Reason \_\_\_\_\_