WELCOME TO PREMIER ORTHOPAEDICS & SPORTS MEDICINE, PLC
WILLIAM J. JEKOT, M.D.

PATIENT INFORMATION

Full Name: *(First)* ______________________ *(Middle)* ______________ *(Last)* ______________________

Address: ____

City: ______________________________ State: ______________ Zip Code: ______________

Home Phone : ______________________ Cell Phone: ______________________

(*circle)* Male / Female Birth Date: ______________ Age: ______________

(*circle)* Married Single Divorced Widowed Social Security # ______________

Patient's Employer: ______________________________ Work Phone: ______________

Employer's Address: ____

RESPONSIBLE PARTY INFORMATION
(Complete this section if patient is a minor or someone *other* than the patient is financially responsible.)

Full Name: *(First)* ______________________ *(Middle)* ______________ *(Last)* ______________________

Address: ____

City: ______________________________ State: ______________ Zip Code: ______________

Home Phone: ______________ Work Phone: ______________ Cell Phone: ______________

Relationship to Patient: ______________ Social Security # ______________ Birth Date: ______________

Name of Employer: ____

EMERGENCY CONTACT INFORMATION

1. Name: ______________________ Relationship: ______________ Phone: ______________
2. Name: ______________________ Relationship: ______________ Phone: ______________

REFERRAL INFORMATION

Who referred you to this office? (c*ircle)* Family / Friends Doctor: ______________________

Other, specify: ______________________ Your family physician is: ______________________

REASON FOR VISIT AND RELATED INFORMATION

Problem to be treated today: ______________________________ (circle) RIGHT SIDE / LEFT SIDE

Please check: ❑ Injury ❑ Auto Accident ❑ On the Job ❑ Other, specify: ______________

❑ Attorney Notified ❑ Employer Notified ❑ Date of Injury / Symptoms Began: ______________

Please circle if done: X-Rays MRI CT Scan Did you bring the films with you? Yes / No

Where were they done? (facility) ____

INSURANCE INFORMATION

1. Primary Insurance: ______________________ Group #: ______________ Policy #: ______________

Name of Insured: ______________ SS # ______________ Birth Date: ______________ Relationship to Patient: ______________

2. Secondary Insurance: ______________________ Group #: ______________ Policy #: ______________

Name of Insured: ______________ SS # ______________ Birth Date: ______________ Relationship to Patient: ______________

Our office will file insurance for all reimbursable services to both your primary and secondary insurance carriers. Please remember that you are responsible for all deductible, co-pay, and non-covered service amounts on the date of service. By signing this form, I agree to be responsible for any legal fees and/or fees incurred in the collection of charges for this account. I authorize the release of any medical information necessary to process my claim(s). I authorize payment(s) of medical and surgical benefits to Premier Orthopaedics & Sports Medicine, PLC.

______________________________________ ______________________

Signature of Patient or Responsible Party *Today's Date*