Joint Reconstructive Specialist Patient Information Sheet

Date_____ JRS Account #_____

Personal Information

Last Name: _____First Name: _____ M: ___

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: (_____)_____ Cell Phone: (_____)_____

Social Security #: _____DOB: _____

Age: _____Sex: _____Marital Status: _____

Employer: _____Employer Phone #: _____

Spouses Information or Responsible Party

Last Name: _____First Name: _____M: _____

Social Security #: _____DOB: _____

Employer: _____

Emergency Contact

Name: _____Telephone#: _____

Relationship to you: _____

Physician

Primary Care Doctor: _____Telephone #: _____

Address: _____

Referring Doctor: _____Telephone #: _____

Please turn over to fill out the insurance portion and sign the authorization for billing purpose. Thank you.

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Insurance Information

Primary

Ins. Carrier Name: _____

Policy #: _____Group #: _____

Name of policyholder if different from patient: _____

Secondary

Ins. Carrier Name: _____

Policy #: _____Group #: _____

Workers Compensation Information if Applicable

Claim #: _____DOI: _____

Employer: _____

Employer Phone Number: (_____)_____

Insurance Carrier (if known): _____

Insurance Carriers Address: _____

OFFICE POLICIES

1. I understand that I am financially responsible for any balance not covered by my insurance carrier.
2. I understand that co-payments are due at time of visit.
3. I understand that I am responsible for informing the receptionist of any changes in address or insurance coverage.
4. I understand that I am responsible for providing a referral from my primary care (PCP) should my insurance carrier require one, and that if one is not received my appointment will be cancelled.

AUTHORIZATION FOR RELEASE OF INFORMATION

I hereby authorize *Joint Reconstructive Specialist* to furnish information to insurance carriers and/or third party payers concerning my illness & treatment. Therefore, I understand I am fully responsible for all fees incurred for service(s) rendered. I hereby assign to the doctor all my payments for medical services rendered to my dependent(s) or myself. I understand this authorization will remain in effect for as long as my dependent(s) or myself remain a patient.

Signature of Patient or Parent/Guardian: _____Date : _____