

# MIDWEST ORTHOPAEDIC CONSULTANTS, S.C.

## PATIENT INFORMATION SHEET

Please complete this entire form, and present your insurance cards so that we may copy them.

PATIENT NAME: \_\_\_\_\_  
Last First MI

Address: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_

Sex: M F Birth Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Age: \_\_\_\_

Social Security Number: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

(Person responsible for treatment authorization and payment:  
Self, Parent, Spouse? Include home mailing address.)

Name: \_\_\_\_\_  
Last First MI

Address: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_

Marital Status of Patient: S M W

Home Phone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Work Phone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Emergency Contact Name: \_\_\_\_\_

Emergency Phone Number: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

(Primary Care Physician)

Referring Physician: \_\_\_\_\_  
Last First

Office Location: \_\_\_\_\_

Is your visit today due to an accident?  Yes  No

If Yes, is the accident work related?  Yes  No

If you answered yes to either question above, please provide the date, and a brief description of the accident and your injury on an additional sheet of paper.

## PRIMARY INSURANCE CARRIER:

Ins Co Name: \_\_\_\_\_

(If PPO or HMO please identify Plan) \_\_\_\_\_

Address: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_

Ins Co Phone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

### Policy Holder Information:

Name: \_\_\_\_\_  
Last First MI

Policy Holder Sex: M F Birth Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Policy Holder Social Security #: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Policy Holder relationship to patient: Self Spouse Child

Insurance ID Number: \_\_\_\_\_

Group Number: \_\_\_\_\_

### EMPLOYER:

(of Ins policy Holder)

Address: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_

Phone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

## SECONDARY INSURANCE CARRIER:

Ins Co Name: \_\_\_\_\_

(If PPO or HMO please identify Plan) \_\_\_\_\_

Address: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_

Ins Co Phone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

### Policy Holder Information:

Name: \_\_\_\_\_  
Last First MI

Policy Holder Sex: M F Birth Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Policy Holder Social Security #: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Policy Holder relationship to patient: Self Spouse Child

Insurance ID Number: \_\_\_\_\_

Group Number: \_\_\_\_\_

### EMPLOYER:

(of Ins policy Holder)

Address: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_

Phone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

I authorize the release of all medical information necessary to process my insurance claim. I assign all medical and/or surgical benefits including major medical benefits to which I am entitled to **Midwest Orthopaedic Consultants, S.C.** I understand that regardless of my insurance, I am financially responsible for the fees for services rendered and all collection and attorney fees if applicable. A photocopy of this assignment is considered as valid as the original. This assignment will remain in effect until revoked by me in writing.

Patient Signature:

(Parent/Guardian) \_\_\_\_\_ Date: \_\_\_\_\_