

FOR OFFICE USE ONLY

PATIENT DEMOGRAPHIC AND AUTHORIZATION FORM

CHART # _____

PLEASE PRINT

DOCTOR _____

DATE _____

PATIENT Last Name First Name Middle Name

Address Phone/Area Code

City, State Zip

Birth Date Mo. Day Yr. Age Sex: Male Female Cell Phone #

Social Security # Marital Status: Single Married Widowed Divorced

Occupation Employer

WK# WHERE PT. CAN BE REACHED EXT#

SPOUSE OR ALTERNATE CONTACT (relation):
NAME
ADDRESS & PHONE IF DIFFERENT FROM PATIENT
TELE#
EMP:
WK#

PARENT/GUARDIAN INFO FOR CHILD/DEPENDENT
FATHER/GUARDIAN:
ADDRESS & PHONE (IF DIFFERENT FROM PATIENT)
TELE#
EMP:
WK#
MOTHER:
ADDRESS & PHONE (IF DIFFERENT FROM PATIENT)
EMP:
WK# EXT:

IS THIS AN ON THE JOB INJURY? YES NO
METHOD OF PAYMENT: CASH CHECK MC VISA or DISC

PRIMARY CARE DR.

REASON FOR APPOINTMENT DATE OF INJURY

REFERRED BY DR. REFERRAL #

MEDICAL INSURANCE INFORMATION

PRIMARY INSURANCE: ID# GRP#

POLICY HOLDER'S NAME DOB SS# (IF NOT ON CARD)

SECONDARY INSURANCE: ID# GRP#

POLICY HOLDER'S NAME DOB SS# (IF NOT ON CARD)

I have read and understand the privacy policy of the Austin Bone and Joint clinic and agree with its principles.

SIGNED DATE

AUTHORIZATION TO RELEASE INFORMATION

THIS IS TO AUTHORIZE AUSTIN BONE & JOINT CLINIC TO RELEASE ANY INFORMATION REGARDING MY CARE TO:

PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE
I authorize the release of any medical or other information necessary to process this claim.

INSURED'S OR AUTHORIZED PERSON'S SIGNATURE
I authorize payment of medical benefits to the physician for services rendered.

SIGNED

SIGNED DATE

Please complete information below, if someone other than the patient is responsible for bill

Name Address

City, State, Zip Phone/Area Code

Relationship to patient Occupation

Employer Address Phone