THE BONE & JOINT CENTER

Orthopaedic Excellence. Exceptional Care.

Patient Check-In

Date: _____

Account Number: _____

Chart Number: _____

Patient Name: _____ Date of Birth: _____ Age: _____

Address: _____

Home Phone: _____ Work Phone: _____

Patient's Employer: _____ Employer's Address: _____

Marital Status: _____ Sex: _____ Patient's Social Security Number: _____

Person Responsible: _____ Address: _____

In case of an emergency, please provide information of the nearest relative not living with you:

Name: _____ Address: _____ Phone: _____

Insurance Information:

Primary Insurance Company: _____

Insurance Company's Address: _____

City: _____ State: _____ Zip: _____

Group Plan Number: _____

Policy or Subscriber's Number: _____

Subscriber Name: _____

Date of Birth: _____

Employer's Name and Address of Subscriber:

_____

Work Phone: _____

Occupation: _____

Secondary Insurance Company: _____

Insurance Company's Address: _____

City: _____ State: _____ Zip: _____

Group Plan Number: _____

Policy or Subscriber's Number: _____

Subscriber Name: _____

Date of Birth: _____

Employer's Name and Address of Subscriber:

_____

Work Phone: _____

Occupation: _____

Work-Related or Auto Accident: _____

Previous X-Rays (When and Where): _____

Medicare Authorization:

I request that payment of authorized Medicare benefits be made either to me or on my behalf to The Bone & Joint Center for any services furnished to me by those providers. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agent any information needed to determine these benefits payable for related services.

Insurance Authorization:

I authorize any holder of medical or other information about me to release medical information as needed for the processing of my claim.

_____

Signature of Patient/Parent/Guardian Date