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Patient Information

Last Name: _____ First Name: _____ M: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Work: _____ Cell: _____

Date of Birth: _____ Age: _____ E-Mail: _____

Gender: F M (circle one) Marital Status: Single Married Other (circle one)

Primary Care Physician: _____ Phone: _____

Address: _____ City: _____ State: _____ Zip: _____

____ Mark if same as PCP

Referring Physician: _____ Phone: _____

Address: _____ City: _____ State: _____ Zip: _____

Pharmacy: _____ City/Location: _____ Phone: _____

Employer: _____ Occupation: _____

Address: _____ City: _____ State: _____ Zip: _____

If not employed, are you a full time student? Y N

We would like to scan your insurance card at your first visit so please bring it with you to the appointment.

Please provide insurance information even if this is work or personal injury related

Health Insurance Info - Policy Holder is: Self Spouse Parent Other: _____ (circle one)

Policy Holder Name: _____ DOB: _____ Group: _____

Can skip to Emergency Contact if you provided insurance card(s) to scan

Primary Ins. Company Name: _____ Policy Number: _____

Secondary Ins. Company Name: _____ Policy Number: _____

Emergency Contact:

Name: _____ Phone: _____ Relationship: _____

Parent or Guardian - Please complete this section if the patient is a minor or full time student:

Last Name: _____ First Name: _____ Initial: _____

Address: (skip if same) _____ City: _____ State: _____ Zip: _____

Relationship to patient: Father Mother Guardian Other: _____

Initials _____ **Date of Birth:** _____ - required on each page to identify document

If this is not related to an injury at work or an auto accident please review statements below and sign the bottom of this page.

Is this injury the result of a WORK or AUTO ACCIDENT? Y N

If yes, please complete the following:

Social Security Number: _____ (needed for work comp claims)

Injury date and time: _____

What body part(s) was/were injured?: _____

If work related, did the injury happen at your current employer? Y N If no, where were you employed?

Claim #: _____ Insurance Carrier: _____

Case/Claim Manager: _____ Phone: _____ Fax: _____

Claims Address: _____

By signing this sheet I agree with the following statements:

- * I have provided accurate demographic and insurance/billing information.**
- * I understand that it is my responsibility to contact Quality Orthopaedic Care if I move, my insurance coverage changes, or if there are any changes to my demographic information provided with this packet.**
- * I authorize Dartmouth-Hitchcock to: bill my insurance company, and if necessary, release my health information to the insurance company to process my medical claim.**
- * I request that my insurance company make payment directly to Dartmouth-Hitchcock for the services they provide.**

Patient/Guardian Signature: _____ Date: _____