



Date: _____

Status: _____

Rec: _____

Patient Information					
ID #:	OrthoWest Physician:			Referring Physician:	
Patient Name:			Marital Status:	Age:	Birthdate:
					Gender:
Patient Address:			City:	State:	Zip:
Primary Phone:		Work Phone:	Cell Phone:		SS #:
Employer (school if student):			Email:		

Billing / Parent Information					
Name:		Address:	City:	State:	Zip:
Relationship:		Birthdate:	Phone:		

Emergency Information		
Name:	Relationship:	Phone:

Insurance Information					
Primary Insurance:			Secondary Insurance:		
Claim Address:			Claim Address:		
City:	State:	Zip:	City:	State:	Zip:
Phone:	Group #:		Phone:	Group #:	
ID #:	Copay:		ID #:	Copay:	
Insured:			Insured:		
Birthdate:	SS#:		Birthdate:	SS#:	
Patient Relation to Insured:			Patient Relation to Insured:		
Employer:			Employer:		

Health Information			
Accident or Injury? ____ Yes ____ No	Worker's Compensation? ____ Yes ____ No	Motor Vehicle Accident? ____ Yes ____ No	Date of Injury:
Primary Physician:		May we send him/her a report of this visit?	
Address:		City:	State: Zip:
DOL Visit:		Skilled Nursing Facility? If yes, Facility Name:	

I authorize OrthoWest as a holder of medical information, to release to my insurance carrier or its intermediaries any information needed for this or future related claims. I acknowledge and understand I am financially responsible for any portion of my bill not covered by my insurance carrier.

If not filing to insurance I will pay \$170 toward anticipated charges, which may include X-rays or supplies. For work related injuries, my personal insurance will be used in the event worker's compensation denies the claim.

Signature _____

Date _____