



Date: \_\_\_\_\_

Status: \_\_\_\_\_

Rec: \_\_\_\_\_

**Patient Information**

ID #:	OrthoWest Physician:	Referring Physician:		
Patient Name:		Marital Status:	Age:	Gender:
Patient Address:		City:	State:	Zip:
Primary Phone:	Secondary Phone (please circle) work / cell:	Birthdate:	SS #:	
Employer (school if student):		Email:		

**Billing / Parent Information**

Name:	Address:	City:	State:	Zip:
Relationship:	Birthdate:	Phone:		

**Emergency Information**

Name:	Relationship:	Phone:
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**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 \_\_\_\_\_