SUN VALLEY ORTHOPEDIC SURGEONS

Complete Entire Section/ Please Print			Employment Information
DATE	☐ MALE ☐ FEMALE	DATE OF BIRTH	PATIENT EMPLOYER NAME & ADDRESS
PATIENT NAME (LAST, FIRST, MIDDLE)			
ADDRESS CITY STATE ZIP			OCCUPATION
PATIENT PHONE PHONE #	PATIENT CELL PHONE#		PATIENT WORK PHONE #
PATIENT SOCIAL SECURITY	EMAIL ADDRESS		BEST TIME TO CONTACT AT WORK

Complete only if responsible party name is different from the patient

SPOUSE/PARENT/LEGAL GUARDIAN	SOCIAL SECURITY #	PHONE #
SPOUSE/PARENT/LEGAL GUARDIAN EMPLOYER	ADDRESS	WORK PHONE#

Emergency Contact

EMERGENCY CONTACT (OUTSIDE OF HOME)	RELATIONSHIP TO PATIENT	CONTACT PHONE #

Primary Care and Referring Doctor Information

PRIMARY CARE PHYSICIAN (NAME, ADDRESS, PHONE #)	REFERRING DOCTOR (NAME, ADDRESS, PHONE #)
REASON FOR VISIT, BODY REGION	TYPE OF INJURY ☐ GRADUAL ONSET / NO ACCIDENT ☐ HOME ☐ RECREATIONAL ☐ AUTO ☐ WORK RELATED ☐ SPORTS ☐ SCHOOL
SIDE EFFECTED ☐ LEFT ☐ RIGHT ☐ BOTH	
LIST INJURY OR APPROXIMATE ONSET OF CONDITION DATE	

Insurance Information ☐ PLEASE CHECK IF YOU HAVE NO INSURANCE

PRIMARY INSURANCE COMPANY	SUBSCRIBER NAME	INSURANCE ID#	GROUP ID#
SECONDARY INSURANCE COMPANY	SUBSCRIBER NAME	INSURANCE ID#	GROUP ID#
STATE/SELF INSURED WORKMAN'S COMP (NAME, ADDRESS, PHONE#)		CLAIM # DATE OF INJURY	CLAIM OPEN ☐ YES ☐ NO

<u>AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS:</u> WE MUST HAVE YOUR AUTHORIZATION TO RELEASE MEDICAL INFORMATION TO YOUR INSURANCE CARRIER OR PHYSICIAN FOR PAYMENT UPON REQUEST. MY SIGNATURE SIGNIFIES THAT AUTHORIZATION.

<u>MEDICARE-LIFETIME AUTHORIZATION:</u> I AUTHORIZE MEDICARE BENEFITS BE MADE TO ME OR ON MY BEHALF TO MY PHYSICIAN FOR ANY SERVICES FURNISHED TO ME BY THAT PHYSICIAN. I AUTHORIZE ANY HOLDER OF MY MEDICAL INFORMATION TO RELEASE ANY INFORMATION TO THE HEALTH CARE FINANCING ADMINISTRATION AND ITS AGENTS THAT MAY BE NEEDED TO DETERMINE THESE BENEFITS OR THE BENEFITS PAYABLE FOR RELATED SERVICES. I HEREBY AUTHORIZE MEDICARE TO FURNISH THE ABOVE NAMED DOCTOR ANY INFORMATION REGARDING MY CLAIMS TITLE XVII OF THE SOCIAL SECURITY ACT.

<u>REFERRAL:</u> I UNDERSTAND THAT IT IS MY OBLIGATION TO OBTAIN A REFERRAL FOR ANY SERVICES IF ONE IS REQUIRED BY MY INSURANCE. THIS REFERRAL MAY ALSO REQUIRE APPROVAL BY MY PRIMARY CARE DOCTOR. IF I FAIL TO PROVIDE AN APPROPRIATE REFERRAL, I ACCEPT FULL RESPONSIBILITY FOR ANY CHARGES INCURRED IN THE COURSE OF TREATMENT.

<u>GUARENTEE OF ELIGIBILITY:</u> I UNDERSTAND I AM FINANCIALLY RESPONSIBLE FOR ANY BALANCE NOT COVERED BY MY INSURANCE CARRIER. I ALSO UNDERSTAND THAT SHOULD I PROVIDE INCORRECT OR UNTIMELY INFORMATION REGARDING MY PRIMARY CARE PROVIDER, MY INSURANCE COVERAGE, OR IF I AM NOT ELIGIBLE UNDER THE TERMS OF MY MEDICAL SUBSCRIBER AGREEMENT, I AM LIABLE FOR ALL CHARGES FOR SERVICES RENDERED. A COPY OF THIS SIGNATURE IS VALID AS THE ORIGINAL.

<u>HIPPA;</u> I HEREBY ACKNOWLEDGE THAT I HAVE BEEN PRESENTED WITH A COPY OF SUN VALLEY ORTHOPEDIC SURGEONS NOTICE OF PRIVACY PRACTICE.

SIGNED: (PATIENT OR PARENT, IF MINOR): -____DATE: ______________________