SEA VIEW ORTHOPAEDIC MEDICAL GROUP

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LAST NAME		WHO SENT YOU HERE		
FIRST NAME	HOME PHONE #	DOB	AGE	DRIVERS LIC #
ADDRESS	APT #	CITY	STATE	ZIP CODE
SOCIAL SECURITY #	SEX (M/F)	MARITAL STATUS	DRUG OR FOOD ALLERGY	
EMPLOYER	OCCUPATION		EMPLOYER PHONE #	
EMPLOYER ADDRESS		CITY	STATE	ZIP CODE
IS YOUR CONDITION WORK RELATED (Y/N)	DATE OF INJURY		REPORTED TO YOUR EMPLOYER (Y/N)	
WHO IS YOUR INTERNIST / FAMILY MEDICINE DOCTOR / PEDIATRICIAN?				
IF THE PATIENT IS A MINOR, PLEASE GIVE US YOUR INFORMATION BELOW				
LAST NAME		YOUR RELATIONSHIP TO PATIENT		
FIRST NAME	HOME PHONE #	DOB	AGE	DRIVERS LIC #
ADDRESS	APT #	CITY	STATE	ZIP CODE
SOCIAL SECURITY #	SEX (M/F)	MARITAL STATUS	DRUG OR FOOD ALERGY	
EMPLOYER		OCCUPATION	EMPLOYER PHONE #	
EMPLOYER ADDRESS		CITY	STATE	ZIP CODE
PRIMARY INSURANCE INFO PLEASE BRING INSURANCE CARD				
INSURANCE NAME AND ADDRESS				
SUBSCRIBER #	GROUP #		COVERAGE FROM (DATE)	COVERAGE TO (DATE)
NAME PRIMARY INSURED		PRIMARY INSURED DOB	PRIMARY INSURED SSN	
INSURED'S EMPLOYER	ADDRESS		PHONE #	

Our office will bill your insurance. You are responsible for the deductible, share of cost, co-payment at time of visit, and any costs not a benefit of your plan. If you do not have insurance we would expect payment at the time of your visit. Our staff is available if you have any questions.
I authorize payment of medical benefits be made directly to the physician provider for services rendered.
I authorize my doctor to release any medical or other information necessary to process claims with my insurance companies. I request payment of any government benefits to the party who accepts assignment. I authorize use of information from this form to bill my insurance companies.

PATIENT SIGNATURE _____ DATE _____