For Office Use Only
Medical Chart Number:_____
Physician:_____

SOUTHWEST ORTHOPAEDIC GROUP©
PATIENT INFORMATION

Instructions: All sections must be completed. If not applicable, please indicate as "N/A."

Was this injury sustained on the job? __Yes __No If so, has a claim been filed with your employer? __Yes __No

PATIENT INFORMATION

Last Name _____ First Name _____ M.I. _____ Nickname_____ ☐ Male ☐ Female
Date Of Birth ____/____/____ Age_____ Social Security # _____-_____-_____ Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorce
Home Address _____ City _____ State _____ Zip _____
Home Phone (____) ____-_____ Work Phone (____) ____-_____ Cell Phone (____) ____-_____ e-mail_____
Employer/School Name _____ Employed: ☐ Full Time ☐ Part Time Student: ☐ Full time ☐ Part time
Employer/School Address _____ City_____ State_____ Zip_____ Phone (_____) _____
Driver's License #_____ State License Issued _____ Primary Care Physician or Family Physician's Name_____

EMERGENCY CONTACT

Primary Contact_____ Relationship _____ Phone (_____) _____-_____ ☐ Hm ☐ Wk ☐ Cell
Secondary Contact_____ Relationship _____ Phone (_____) _____-_____ ☐ Hm ☐ Wk ☐ Cell

REFERRED BY

Doctor_____ Hospital/Clinic _____ Patient _____
Family Member _____ HMO/PPO Directory _____ Employer _____
Print Advertising _____ Internet _____ School _____
Other_____

PRIMARY INSURANCE

(Please complete blanks with subscribers/primary insurance holders information)
Subscribers Name_____
☐ Male ☐ Female Date Of Birth _____/_____/_____
Social Security # _____-_____-_____
Patient's Relationship to Subscriber_____
Employer_____
Employer's Address_____
City_____ State_____ Zip_____
Insurance Co Name _____
Phone # (_____) _____-_____
Claims Filing Address _____
City_____ State_____ Zip_____
Identification # _____ Group # _____

SECONDARY INSURANCE

(Please complete blanks with subscribers/primary insurance holders information)
Subscribers Name _____
☐ Male ☐ Female Date Of Birth _____/_____/_____
Social Security # _____-_____-_____
Patient's Relationship to Subscriber _____
Employer _____
Employer's Address _____
City_____ State _____ Zip _____
Insurance Co Name _____
Phone # (_____) _____-_____
Claims Filing Address _____
City_____ State _____ Zip _____
Identification # _____ Group #_____

GUARANTOR (if patient is a minor)

Last Name _____ First Name_____ M.I. _____ ☐ Male ☐ Female
Date Of Birth _____/_____/____ SS#: _____-_____-_____ Driver's License #_____ State License Issued _____
Relationship to patient _____
Address _____ City_____ State_____ Zip_____
Home Phone (_____) _____-_____ Work Phone (_____) _____-_____ Cell Phone (_____) _____-_____

Have you ever been treated by one of the physicians at Southwest Orthopaedic Group? ☐ No ☐ Yes
If yes, which physician _____ Approximate date _____/_____/_____

CONSENT FOR TREATMENT: I hereby consent to necessary examination procedures and/or treatment by my physician, his/her assistants, designees as is necessary in his/her judgment.
FINANCIAL RESPONSIBILITY: I acknowledge full financial responsibility for services rendered. I also understand that payment of charge incurred is due at time of services.
AUTHORIZATION TO RELEASE INFORMATION: I hereby understand and acknowledge I have been provided with a Notice of Privacy Practices. I hereby consent to releasing information for the purposes of treatment, payment, or health care operations.
ASSIGNMENT OF BENEFITS: I hereby authorize my insurance benefits to be paid directly to Southwest Orthopaedic Group. I have read and dully understand the above consent for treatment, financial responsibility, release of medical information and insurance authorization.

Date _____ Signature (patient, parent, or guardian) _____ Relationship _____