

## OLYMPIA ORTHOPAEDIC ASSOCIATES

### Complete Entire Section/Please Print

### Employment Information

DATE	<input type="checkbox"/> MALE	DATE OF BIRTH	PATIENT EMPLOYER NAME & ADDRESS	
PATIENT NAME (LAST, FIRST, MIDDLE)				
ADDRESS: CITY		STATE	ZIP	OCCUPATION
STREET/APT #		<input type="checkbox"/> UNEMPLOYED		
PATIENT HOME PHONE #	PATIENT CELL PHONE #		PATIENT WORK PHONE #	
PATIENT SOCIAL SECURITY #			BEST TIME TO CONTACT AT WORK	

### Complete only if the responsible party name is different from patient name

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 #
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### Primary Care & Referring Doctor Information

PRIMARY CARE PHYSICIAN (NAME, ADDRESS, PHONE #)	REFERRING DOCTOR (NAME, ADDRESS, PHONE #)
REASON FOR VISIT, BODY REGION	TYPE OF INJURY  <input type="checkbox"/> GRADUAL ONSET / NO ACCIDENT <input type="checkbox"/> HOME <input type="checkbox"/> RECREATIONAL <input type="checkbox"/> AUTO <input type="checkbox"/> WORK RELATED <input type="checkbox"/> SPORTS <input type="checkbox"/> SCHOOL
SIDE AFFECTED <input type="checkbox"/> LEFT <input type="checkbox"/> RIGHT <input type="checkbox"/> BILATERAL	
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 #
SECONDARY INSURANCE COMPANY	SUBSCRIBER NAME	INSURANCE ID #	GROUP #
STATE/SELF INSURED WORKMAN'S COMP. (NAME, ADDRESS, PHONE #)		CLAIM #	CLAIM OPEN  <input type="checkbox"/> YES <input type="checkbox"/> NO
		DATE OF INJURY	

#### **AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS:**

WE MUST HAVE YOUR AUTHORIZATION TO RELEASE MEDICAL INFORMATION TO YOUR INSURANCE CARRIER OR PHYSICIAN FOR PAYMENT UPON REQUEST. MY SIGNATURE VERIFIES THAT AUTHORIZATION.

#### **MEDICARE-LIFETIME AUTHORIZATION:**

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 MEDICARE CLAIMS TITLE XVII OF THE SOCIAL SECURITY ACT.

#### **REFERRAL:**

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.

#### **GUARANTEE OF ELIGIBILITY:**

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.

PATIENT/RESPONSIBLE PARTY: \_\_\_\_\_ DATE: \_\_\_\_\_

Signature