

WOODFIELD ORTHOPAEDICS & SPORTS MEDICINE, LTD
PATIENT INTAKE FORM

NAME _____ DATE ____/____/____

ADDRESS _____

DATE OF BIRTH _____
Street / / City State Zip
SOCIAL SECURITY # _____ - _____ - _____ SEX ___ M ___ F

MARITAL STATUS ___ S ___ M ___ D ___ W HAND DOMINANCE right ___ left ___ ambidextrous ___

HOME PHONE # _____ CELL PHONE# _____ WORK PHONE# _____

EMPLOYER _____ OCCUPATION _____

EMPLOYER ADDRESS _____

PHARMACY _____
Street City State Zip

ADDRESS _____ PHONE # _____

PRIMARY CARE DR. _____

ADDRESS _____

REFERRING DR. _____
Street City State Zip

ADDRESS _____

Street City State Zip

IN CASE OF EMERGENCY NOTIFY _____

HOME PHONE# _____ CELL# _____ WORK# _____ EXT _____

RELATIONSHIP TO PATIENT _____

INSURANCE INFORMATION

(Please give your Drivers License and insurance card (s) to the receptionist.)

PERSON RESPONSIBLE FOR PAYMENT _____

ADDRESS _____ PHONE # _____
Street City State Zip

PRIMARY INSURANCE CO. _____ GROUP # _____ POLICY # _____

POLICY HOLDER _____ DATE OF BIRTH ____/____/____ SSN ____ - ____ - ____

RELATIONSHIP TO PATIENT _____

SECONDARY INSURANCE CO _____ GROUP# _____ POLICY# _____

POLICY HOLDER _____ DATE OF BIRTH ____/____/____ SSN ____ - ____ - ____

RELATIONSHIP TO PATIENT _____

I AUTHORIZE RELEASE OF ALL TREATMENT INFORMATION NEEDED TO PROCESS MY INSURANCE CLAIM. I AUTHORIZE PAYMENT OF BENEFITS DIRECTLY TO DR. SALTZMAN/WOODFIELD ORTHOPEDICS & SPORTS MEDICINE. I UNDERSTAND THAT I AM RESPONSIBLE FOR PAYING ANY OR ALL BALANCE(S) DUE ON MY ACCOUNT FOR SERVICES RENDERED.

DATE ___/___/___

SIGNATURE_____

I DO HEREBY GRANT PERMISSION THAT MY PHYSICIAN AND ALLIED PERSONNEL TO ADMINISTER MEDICATION AND PERFORM SUCH PROCEDURES AS MAY BE DEEMED NECESSARY IN THE INTEREST AND CARE OF THE MEMBERS OF MY FAMILY ANY MYSELF.

DATE ___/___/___

SIGNATURE_____