# TALLGRASS ORTHOPEDICS AND SPORTS MEDICINE
## INSURANCE INFORMATION

**Complete Box 1-health insurance needed on all patients**
**Complete Box 1 and 2 if auto accident injury**
**Complete Box 1 and 3 if work comp injury**

**PATIENT NAME**______________________________

**1.** **HEALTH INSURANCE**

***PRIMARY***
Insurance Name and Address

ID Number ______________________ Group Number ______________________ Relationship to Patient ______________________

Policyholder Name ______________________ Policyholder Address ______________________ Policyholder Date of Birth ______________________

***SECOND INSURANCE***
Insurance Name and Address

ID Number ______________________ Group Number ______________________ Relationship to Patient ______________________

Policyholder Name ______________________ Policyholder Address ______________________ Policyholder Date of Birth ______________________

***THIRD INSURANCE***
Insurance Name and Address

ID Number ______________________ Group Number ______________________ Relationship to Patient ______________________

Policyholder Name ______________________ Policyholder Address ______________________ Policyholder Date of Birth ______________________

**2.**

**If you were injured in an AUTO ACCIDENT please complete box 1 and 2**

Date of Accident ______________________ Claim Number ______________________

Name and Address of Insurance Company

Adjuster Name ______________________ Insurance Company Phone Number (____)______________________

**3.** **If you were injured at WORK please complete box 1 and 3**

Date of Injury ______________________ _____ Claim Number ______________________

Work Comp Insurance Name and Address Phone number

Claim Representative and or Case Manager ______________________ Case Manager Phone Number (______)______________________

Employer at Time of Injury Employer Phone Number ______________________ Case Manager fax number (_____)______________________

Acknowledgement of Receipt of Notice of Privacy Practices Federal Regulations requires that Tallgrass Orthopedic & Sports Medicine obtain proof that patients have received the Notice of Privacy Practices. My signature below indicates only that I have received a copy of Tallgrass Orthopedic & Sports Medicine's Notice of Privacy Practices, not that I have read it or agree with its contents.

______________________________ ______________________

Person receiving Notice of Privacy Practices Date