TALLGRASS ORTHOPEDICS AND SPORTS MEDICINE

LAST NAME **FIRST** **MI** **MAIDEN NAME** **Female** ☐ **Male** ☐

_____

HOME ADDRESS: **CITY** **STATE** **ZIP**

_____

HOME PHONE **CELL PHONE:** **MARTIAL STATUS:** ☐ **SINGLE** ☐ **MARRIED**

(____)_____ **(____)_____** ☐ **WIDOWED** ☐ **DIVORCED** ☐ **SEPARATED**

SOCIAL SECURITY NO. **DATE OF BIRTH** **AGE**

_____ _____ _____

PATIENT'S EMPLOYER NAME **OCCUPATION** **WORK PHONE**

_____ _____ **(____)_____**

WHAT ARE WE SEEING YOU FOR TODAY:_____

NAME OF INDIVIDUAL Responsible for paying bills **ADDRESS** **PHONE**

_____ _____ **(____)_____**

PRIMARY PHYSICIAN **REFERRED BY**

_____ _____

EMERGENCY CONTACT (someone who does not live with you) **PHONE**

_____ **(____)_____**

SPOUSE/PARENT NAME **ADDRESS** **PHONE**

_____ _____ **(____)_____**

SPOUSE/PARENT EMPLOYER **SPOUSE/PARENT SS#** **SPOUSE DATE OF BIRTH**

_____ _____

_____

AUTHORIZATIONS

I hereby authorize Tallgrass Orthopedic & Sports Medicine to furnish my referring physician, if any, and/or insurance company(s) all information which said parties may request concerning my illnesses or injuries. If Tallgrass Orthopedic & Sports Medicine chooses to accept assignment of my insurance benefits, I hereby assign to Tallgrass Orthopedic & Sports Medicine all money to which I am entitled for medical and/or surgical expense relative to the service reported, but not to exceed my indebtedness to said Professional Association. It is understood that any money received from the above named party, over and above my indebtedness, will be refunded to me when my bill is paid in full. I understand that I am financially responsible to Tallgrass Orthopedic & Sports Medicine for all charges. This authorization may be revoked at any time in writing.

A PHOTOSTATIC COPY OF THIS AUTHORIZATION SHALL BE CONSIDERED AS EFFECTIVE AND VALID AS THE ORGINIAL

☐ **RELEASE OF INFORMATION: Other Involved in My Care:**

I Herby authorize Tallgrass Orthopedics to release my protected health information to the following _____

RELATIONSHIP ☐ Parents ☐ Spouse ☐ Children ☐ Other: _____

_____

_____

PATIENT or REPRESENTATIVE SIGNATURE **DATE**

CO PAYS ARE DUE AT TIME OF SERVICE