

Patient _____ **DOB** _____ **SSN** _____ **Marital Status:** _____
Mailing Address _____
City _____ State _____ Zip _____
Home Phone _____ Cell Phone _____
Employer _____ Work Phone _____ ext _____

Parent/Guardian _____ **Birthdate** _____ **SSN** _____ **Relationship** _____
Address (if different) _____ Employer _____
Home Phone _____ Work Phone _____ ext _____ Cell Phone _____

As a courtesy, we bill your medical insurance. All co-insurance and co-pays are due at time of service, unless prior financial arrangements have been made with our credit department.

Primary Insurance _____ **Policy** _____ **Group** _____
Policy Holder's Name _____ **Birthdate** _____ **Relationship** _____
Address if different from patient _____

Secondary Insurance _____ **Policy** _____ **Group** _____
Policy Holder's Name _____ **Birthdate** _____ **Relationship** _____
Address if different from patient _____

Third Insurance _____ **Policy** _____ **Group** _____
Policy Holder's Name _____ **Birthdate** _____ **Relationship** _____
Address if different from patient _____

	YES	NO
IS THIS AN ON THE JOB INJURY*	<input type="checkbox"/>	<input type="checkbox"/>
AUTO ACCIDENT**	<input type="checkbox"/>	<input type="checkbox"/>
OR OTHER LIABILITY INJURY**	<input type="checkbox"/>	<input type="checkbox"/>

*If work related please complete 827 form.
**If auto or other accident please complete accident form.

I authorize Klamath Orthopedic to disclose medical and/or billing information on my behalf to the friends/family listed below. Klamath Orthopedic will not release any information to parties not listed on this written consent.

Name _____ **Phone** _____ **Relation** _____
____ **Medical Information** ____ **Billing Information** ____ **Emergency contact**

Name _____ **Phone** _____ **Relation** _____
____ **Medical Information** ____ **Billing Information** ____ **Emergency contact**

Name _____ **Phone** _____ **Relation** _____
____ **Medical Information** ____ **Billing Information** ____ **Emergency contact**

I have been provided with HIPAA guidelines and Federal Red Flag Rules.

Signed _____ **Date** _____ **Relationship to Patient** _____