Olsen Orthopedics Patient Information *Please complete all information

Name _____ (First) _____ (MI) _____ (Last) M F (Sex) / / (DOB) _____ (Age)

Address _____ (Street Address) _____ (City) _____ (State) _____ (Zip)

Phone # _____ (Home) _____ (Cell) - - (Social Security #)

Height _____ Weight _____ Email _____

Patient Employer _____ Work Phone _____

If A Patient is a Minor, Responsible Party

Name _____ (First) _____ (MI) _____ (Last) - - (Social Security #)

Address _____ (Street Address) _____ (City) _____ (State) _____ (Zip)

Pharmacy Information

Name of Pharmacy _____

Location _____

Phone _____ Fax _____

Health Insurance Information

Primary Insurance _____ Policy Holder _____

- - (Social Security #) / / (DOB)

_____ (Policy #) _____ (Group #)

Secondary Insurance _____ Policy Holder _____

- - (Social Security #) / / (DOB)

_____ (Policy #) _____ (Group #)

Referred by: _____

Primary care physician: _____

Cardiologist: _____

Who should we contact in case of an emergency?

(Name) _____ (Phone #) _____

Required Authorizations *Please take a moment to complete the following required consents

Benefits to Physician:I hereby authorize payments directly to Olsen Orthopedics of the surgical and/or medical benefits.
I understand that I am resposible for any portion of my bill not covered by my insurance company within the terms of its contract.

Release of Information:I hereby authorize release of information necessary for filing my insurance claim/filing a payment review.

I have received a Notice of Privacy Practices from the office of Olsen Orthopedics.

I have signed the patient consent for use and disclosure of protected health information from the office of Olsen Orthopedics.

_____ (Signature) _____ (Date)