

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

Address _____
Street Address City State Zip

Phone # _____ Cell _____ Social Security # _____
Home

Height _____ Weight _____ Email _____

Patient Employer _____ Work Phone _____

If A Patient is a Minor, Responsible Party

Name _____ Social Security # _____
First MI Last

Address _____
Street Address City State Zip

Pharmacy Information

Name of Pharmacy _____

Location _____

Phone _____ Fax _____

Health Insurance Information

Primary Insurance _____ Policy Holder _____

_____ / / _____
Social Security # DOB

_____ Group # _____
Policy #

Secondary Insurance _____ Policy Holder _____

_____ / / _____
Social Security # DOB

_____ Group # _____
Policy #

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 responsible 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 _____