

Patient Information

Patient's Name _____ Date: _____

Address _____ Social Security # _____
Street City State Zip

Date of Birth _____ Age _____ Place of Employment _____

Sex _____ Marital Status _____ Phone: Home _____ Work: _____

Cell Number: _____ Email Address: _____

Responsible Party (if minor)

Mailing Address of Responsible Party:

Spouse's Name _____ Spouse's Date of Birth _____

Spouse's Place of Employment _____ Work Phone _____

Is your visit today a result of:

Auto Accident? [] Yes [] No Fall or trauma? [] Yes [] No On the job injury? [] Yes [] No

Long term problem? [] Yes [] No Is there litigation pending? [] Yes [] No

Date of Injury _____ Initial Place of Treatment _____

X-rays Taken? [] Yes [] No

If on the job injury, have you reported this to your employer? [] Yes [] No

Workers' Compensation Information (if applicable):

Employer _____ Contact Person _____

Address _____ Telephone _____

Insurance Information

Primary Insurance Carrier

Policyholder Name _____ Policyholder Date of Birth _____

Policy # _____ SS# _____ Group # _____

Secondary Insurance Carrier

Policyholder Name _____ Policyholder Date of Birth _____

Policy # _____ SS# _____ Group # _____

Your family physician _____ . Who referred you to this office? _____

In case of emergency, please notify: _____
Name Address Telephone

I hereby authorize Tidewater Orthopaedic Associates, Incorporated to provide medical treatment and furnish information to insurance carriers concerning illness/injuries and treatment and I hereby assign to the doctor all payments for medical services rendered to myself or my dependents, I understand that I am responsible for any amount not covered by my insurance, I also understand that in the event of default on any payment due to Tidewater Orthopaedic Associates, Incorporated, I am responsible for payment of 33% cost of collection and or attorney's fees.

Patient/Responsible Party Signature: _____