



Patient Information

Patient's Name: _____ Date: _____

Address: _____
City State Zip

Date of Birth: _____ SSN: _____ Age: _____ E-mail Address: _____

Sex: _____ Marital Status: _____ Place of Employment: _____

Phone Numbers: Home _____ Work _____ Cell _____

Spouse's Name: _____ Spouse's DOB _____

Spouse's Place of Employment: _____ Work # _____

Responsible Party (if minor) _____ DOB: _____ SSN: _____

Mailing Address of Responsible Party: _____ Place of Employment: _____

Who is your primary care physician? _____

Emergency Contact _____ Relationship _____ Phone Number _____

Primary Insurance Provider: _____

Subscribers Name: _____ SSN: _____ DOB: _____

I.D. # _____ Group# _____

Secondary Insurance Provider: _____

Subscribers Name: _____ SSN: _____ DOB: _____

I.D. # _____ Group#: _____

Workers' Compensation Patients

Workers'Comp Carrier(employer) _____ Claim Number: _____

Who is your case manager? _____ Phone: _____

CONSENT TO TREATMENT

I hereby authorize Tidewater Orthopaedic Associates, Inc. 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, Inc., I am responsible for payment of 33% cost of collection and attorney's fees.

Patient/Responsible Party Signature: _____