PATIENT INFORMATION

Patient's Name (First MI Last)	__Male __Female	Date of Birth	Age	Social Security Number

Address	City and State	Zip Code	Home Phone

Patient's Employer	Business Phone	Driver's License	Referring Doctor	Cell Phone

Marital Status M S W D	Spouse's Name	Spouse's Employer	Date of Birth	Social Security Number

PLEASE FILL OUT IF PATIENT IS A MINOR OR A FULL TIME STUDENT

Mother's Name	DOB	Social Security Number	Father's Name	DOB	Social Security Number

Billing Address	City and State	Zip Code	Emergency Phone

INSURANCE INFORMATION

Primary Insurance Information	Name of Policy Holder	Employer	Relationship to Patient

Identification Number	Group Number	Insurance Phone Number

Secondary Insurance Information	Name of Policy Holder	Employer	Relationship to Patient

Identification Number	Group Number	Insurance Phone Number

Due to: ☐ Illness ☐ Injury Work Related _____ Yes _____ No Auto Accident _____ Yes _____ No

Date of Injury _____

Where injury occurred: _____

MEDICARE/MEDICAID PATIENTS ONLY

I certify that Medicare information given by me is correct. As this office does accept assignment with Medicare, this information will be used for this purpose of processing my Medicare claims for payment. I understand due to government regulations, that if Medicare coverage is available to me, I must inform my physicians. I also understand, if in addition to Medicare, I am covered under any EMPLOYER GROUP HEALTH INSURANCE, LIABILITY, NO-FAULTS, WORKER'S COMPENSATION or any other insurance which may be responsible for payment, I must inform this office. I have read and understand the statement regarding Medicare coverage.

____ Medicare is my Primary coverage
____ Medicare is my Secondary coverage
____ I do not have Medicare/HMO
____ I do not have Medicaid/HMO

Medical Authorization Assignment of Benefits	*Release of Information*	*Consent to Care*
I hereby authorize Fondren Orthopedic Group L.L.P. to furnish information to my insurance carrier(s) concerning me or my dependents illness or treatment and assign to the physicians all payments for medical and surgical services rendered to my dependents or myself. The undersigned hereby unconditionally guarantees full and prompt payment of all charges incurred as a result of services rendered to me during the course of my medical a treatment.	I hereby authorize Fondren Orthopedic Group L.L.P. to release any or all information acquired in the course of my examination and/or treatment. I understand this may include the release of any medical or other health information required in the processing of claims for payment. I also authorize the release of information to another doctor or health care facility to which the patient may be transferred or referred.	I authorize and direct Fondren Orthopedic Group L.L.P. to perform upon me injections, draw blood and/or any other procedure or treatments the doctor may in his best judgement determine advisable for my well being.
X_____	X_____	X_____
Signature of Patient/Parent/or Guardian Date	Signature of Patient/Parent/or Guardian Date	Signature of Patient/Parent/or Guardian Date