CAPSTONE orthopedic

PATIENT INFORMATION FORM

Social Security#: - -

(Mr. Mrs. Ms.) Patient Name: Date of Birth:

Address: City: State: Zip:

Phone# :( ) Cell# :( ) Married? Y/N

Parent/Guardian Name:

Emergency Contact Name: Phone# :( ) Relationship To Patient:

Living In A Nursing Facility: Y/N If Yes, Facility Name: Phone#:( )

Employer Name: Work#: ( )

Email Address: Would you like us to e-mail you appointment reminders? Y/N

Medical History:

Referring Physician: Primary Physician:

Are you Diabetic? Y/N Name of Diabetic Physician: Phone Number# :( )

Insurance Information:

Primary Insurance Name: Address:

Policy#: Group#: Policy Holder Name:

Policy Holder Date of Birth: / / Policy Holder Social#:

Secondary Insurance Name: Address:

Policy#: Group#: Policy Holder Name:

Policy Holder Date of Birth: / / Policy Holder Social#:

Worker's Compensation:

Ins Company: Phone Number: ( ) Claim Number:

Date of Injury: Claims Adjuster: Employer:

AUTHORIZATION TO ASSIGN BENEFITS TO PROVIDER & RELEASE OF MEDICAL INFORMATION:

I request that payment of authorized Medicare, Medicaid, Private Insurance and Other Benefits be made on my behalf to the above company for products and services that they have provided for me. I further authorize a copy of this agreement to be used in place of the original and authorize any holder of medical information about me to release to the Centers for Medicare and Medicaid services and its Agents or Others, any information needed to determine these benefits or compliance with current health standards. I acknowledge having received a copy of Capstone Orthopedic Inc.'s 1) Notice of Privacy Policies, 2) Medicare Supplier Standards and 3) Financial Policy.

Signature of Patient/ Responsible Party **Today's Date**

Printed Name of Responsible Party **Relationship to Patient**