



An Affiliate of Orthopedic Centers of Idaho, PA

Dr. _____

Appt. Date _____

Patient Information

Patient's Last Name _____ First _____ Middle _____ F _____ M _____

Mailing Address _____ City _____ State _____ Zip _____

Patient's Social Security No. _____ Home Phone _____ Cell Phone _____ Work Phone _____

Age _____ Date of Birth _____ Single _____ Married _____ Divorced _____ Widowed _____

Patient's Employer _____ Years with Firm _____ Occupation _____

Spouse's Name _____ Employer _____ Work Phone _____

Spouse's Social Security No. _____ Occupation _____

Father's Name (IF MINOR) _____ Employer _____ Work Phone _____

Father's Social Security No. _____ Occupation _____

Mother's Name (IF MINOR) _____ Employer _____ Work Phone _____

Mother's Social Security No. _____ Occupation _____

Nearest Relative _____ Relationship _____ Phone _____

Family Physician _____ Referred By _____

Whom May We Contact in Case of Emergency? _____ Phone _____

Insurance Information

Date of accident/injury or onset of symptoms _____

Is this a Worker's Compensation claim? Yes _____ No _____

If yes, have you signed a Worker's Compensation form? Yes _____ No _____

Is this an Idaho claim? Yes _____ No _____ (Out of state claim?) Yes _____ No _____

How Did You Hear About Us? pick one

Cable/TV Ad Radio Ad

Family/Friend Web Ad

Physician Referral Insurance Plan

Yellow Pages I'm A Former Patient

PRIMARY INSURANCE COMPANY NAME _____

Insurance Co. Address _____

Insurance Co. Phone _____ Subscriber Name _____ D.O.B. _____

Patient Relationship to Subscriber. Please circle one. (self, spouse, child)

I.D. No. _____ Group No. _____

SECONDARY INSURANCE COMPANY NAME _____

Insurance Co. Address _____

Insurance Co. Phone _____ Subscriber Name _____ D.O.B. _____

Patient Relationship to Subscriber. Please circle one. (self, spouse, child)

I.D. No. _____ Group No. _____

DOES YOUR INSURANCE COMPANY REQUIRE A SECOND OPINION? Yes _____ No _____

DOES YOUR INSURANCE COMPANY REQUIRE PRE-AUTHORIZATION FOR SURGERY AND/OR ADMISSION? Yes _____ No _____

Please Read & Sign Below

Recognizing the inherent risks of transmission of contagious diseases, especially during surgery, I voluntarily agree to be tested for such diseases as hepatitis, syphilis, HIV/AIDS, herpes, etc., when deemed necessary by physician. Questions should be discussed with your physician. I hereby authorize the doctors of the Boise Orthopedic Clinic, to furnish the insured's insurance company all information which said insurance company may request concerning my present illness or injury. I hereby assign to the doctors all money to which I am entitled for medical and/or surgical expense relating to the services performed from time to time, but not to exceed my indebtedness to said physicians and surgeons. It is understood that any money received from the above named insurance company over and above my indebtedness will be refunded to me or, in the proper case, to my employer or other provider of insurance, when my bill is paid in full. I understand I am financially responsible to said doctors for charges not covered by this assignment. I further authorize the doctor's office to make photocopies of this authorization and assignment, in order for them to attach a copy to any insurance form and to be able to retain the original copy in the doctor's files, and authorize the insurance company to accept the photocopy. I release you from all legal responsibility or liability that may arise from this authorization. This authorization shall continue and be in force and effect until revoked in writing by me.

_____ Date _____

RESPONSIBLE PARTY'S SIGNATURE