

This Section To Be Filled Out By IOC	Medical Record #
	IOC Staff Initials:

Today's Date: _____

Patient Name: _____
Last First Middle

Social Security#: _____ Birthdate: ___/___/___ Male Female

Marital Status: Single Married Separated Divorced Widowed

Patient Address: _____ Apt/Lot#: _____

City: _____ State: _____ Zip: _____

Email address: _____

Patient Employer Name: _____

Primary Care Physician: _____

Referring Physician: _____

Primary contact for minor child: _____ Phone #: _____

If patient is a minor, please list the parents/stepparents full name:

1. _____ Relationship to Patient: _____

2. _____ Relationship to Patient: _____

INSURANCE INFORMATION

Primary Insurance: _____

Card Subscriber's Name: _____

Relationship to Patient: _____ Co-pay/Co-Insurance: _____

Identification #: _____ Group #: _____

Subscriber's Birthdate: ___/___/___ Social Security #: _____ Employer: _____

Secondary Insurance: _____

Card Subscriber's Name: _____

Relationship to Patient: _____ Co-pay/Co-Insurance: _____

Identification #: _____ Group #: _____

Subscriber's Birthdate: ___/___/___ Social Security #: _____ Employer: _____

Third Insurance: _____

Card Subscriber's Name: _____

Relationship to Patient: _____ Co-pay/Co-Insurance: _____

Identification #: _____ Group #: _____



Patient Information Form

Subscriber's Birthdate: ____/____/____ Social Security #: _____ Employer: _____

Patient Name: _____
Last First Middle

CAUSE OF INJURY Date of Accident/Injury: _____

Work Accident or Work Related Injury

Has medical treatment been authorized by your employer? Yes No

Name and address of company and/or representative to contact for verification:

Phone #: _____ Fax#: _____

Liability Injury (i.e. another party may be at fault and/or we are billing someone besides your Health Insurance Company)

Occurred in your home

Occurred in or on someone else's home or property

Occurred at a place of business (other than your workplace)

Occurred in a motor vehicle

None of the Above: (please describe) _____

Other: (please describe) _____

SKILLED NURSING CENTER PATIENTS

If you are in a skilled medical nursing facility (permanently or temporarily residing in a nursing home or rehabilitation center), we will need to know the facility's name and address:

Facility Name: _____

Facility Address: _____

HOW WERE YOU REFERRED TO OUR OFFICE?

Referring Doctor Phone Book Friend/Relative Internet

Newspaper (Please List): _____ TV Commercial

Other (Please List): _____

I hereby authorize you to release all information necessary to secure payment of said benefits. I understand that it is my responsibility that all incurred charges are paid. I further understand that if I want you to file my insurance, I must provide you with necessary numbers and completed forms, including making a copy of insurance ID card(s).

I hereby assign all medical and/or surgical benefits to which I am entitled, including Medicare and other government sponsored programs, private insurance, and other health plans, to Iowa Orthopaedic Center, P.C. (IOC). A photocopy of this authorization shall be considered as effective and valid as the original. This authorization shall be considered valid for one year from the original date signed.

My signature below indicates that I have been provided a copy Iowa Orthopaedic Center, P.C. Patient Financial Policy



Patient Information Form

and that I thoroughly understand the policy. **I understand that I am financially responsible for all charges incurred, whether or not paid by said insurance.**

My signature below acknowledges that a copy of the Iowa Orthopaedic Center, P.C. NOTICE OF PRIVACY PRACTICES has been made available to me.

Signature: _____

Date: _____