IOWA ORTHO
A CENTER OF EXCELLENCE®

Patient Information Form

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 parent/stepparents full names:

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 #: ____

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

Patient Information Form

Patient Name: ____
Last First Middle

INJURY/CONDITION INFORMATION

Date Accident/Injury occurred: ____________________________ or Date when Condition began:_________________

☐ 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 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. (Iowa Ortho). 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 of the Iowa Ortho Patient Financial Policy 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 Ortho NOTICE OF PRIVACY PRACTICES has been made available to me.

Signature: ____ Date: _________________