

Orthopaedic Associates of Arkansas

Date _____
Doctor _____
Chart # _____

Patient Information:

Patient's Legal Name: Last _____ First _____ M.I. _____ Male _____ Female _____
Social Security # _____ Date of Birth _____ Age _____ Phone # _____
Home Address _____ City _____ State _____ Zip _____
Patient's Employer: (If none, state NONE) _____ Position _____ Phone # _____
Employer's Address _____ City _____ State _____ Zip _____
Marital Status: _____ Single _____ Married _____ Divorced _____ Widowed
Spouse's Name: Last _____ First _____ M.I. _____
Male _____ Female _____ Social Security # _____ Date of Birth _____ Age _____
Spouse's Employer _____ Position _____ Phone # _____
Employer's Address _____ City _____ State _____ Zip _____
In case of emergency, who may we notify? (Contact Person) _____
Relationship to patient _____ Phone Number _____

Responsible Party's Information:

(This section MUST be completed for patients that are 17 years old or younger.)

Relationship to patient: _____ self _____ spouse _____ parent _____ other (specify) _____
Name: Last _____ First _____ M.I. _____
Address _____ City _____ State _____ Zip _____
Phone # _____ Social Security # _____ Date of Birth _____ Age _____
Employer _____ Position _____ Phone Number _____
Employer's Address _____ City _____ State _____ Zip _____

Primary Insurance Information:

(OUR OFFICE REQUIRES PHOTOCOPIES OF ALL INSURANCE CARDS) (If no insurance, please circle NONE)

Is this a work related injury? _____ yes _____ no Is this due to an automobile accident? _____ yes _____ no
Name of Insurance Company _____ Policy # _____ Group # _____
Address _____ City _____ State _____ Zip _____
Phone Number _____ Does your primary insurance company require a referral? _____ yes _____ no
Name of Insured _____ Date of Birth _____ Age _____
Employer of Insured _____ Position _____ Phone # _____
Address of Employer _____ City _____ State _____ Zip _____

Secondary Insurance Information:

Name of Insurance Company _____ Policy # _____ Group # _____
Address _____ City _____ State _____ Zip _____
Phone Number _____ Does your secondary insurance company require a referral? _____ yes _____ no
Name of Insured _____ Date of Birth _____ Age _____
Employer of Insured _____ Position _____ Phone # _____
Address of Employer _____ City _____ State _____ Zip _____
If no insurance, will you pay by? Cash _____ Check _____ Credit Card _____
Do you need to speak to our Accounts Manager for payment arrangements? _____
Who is your family physician or referring physician? _____
City _____ State _____ Zip _____ Phone Number _____

Assignment of Insurance Benefits/Release of Medical Information:

I request that payment of my insurance benefits be made on my behalf to Orthopaedic Associates of Arkansas for any services furnished me by this group of physicians. I authorize any holder of medical information about me be released if needed to determine these benefits. I understand I am financially responsible for any balance not covered by my insurance or due to deductible, co-pay, or co-insurance as determined by my insurance company. By signing below, I also give authorization for treatment.

Signed _____ Date _____