THE ORTHOPEDIC TOCA CLINIC ASSOCIATION

PATIENT INFORMATION

PATIENT NAME Last	First	M.I.	SOCIAL SECURITY NUMBER	DATE OF BIRTH

ADDRESS	City	State	Zip	HOME PHONE NUMBER CELL/ALT NUMBER

E-MAIL:_____ By entering EMAIL I give The Orthopedic Clinic Association consent to communicate with me via email	SEX	MARITAL STATUS

SEASONAL ADDRESS Street City State Zip

EMPLOYER	PHONE NUMBER

EMPLOYER ADDRESS Street City State Zip

RACE	**ETHNICITY**

ACCIDENT/INJURY INFORMATION

ARE YOU BEING SEEN TODAY FOR AN INJURY RELATED TO AN ACCIDENT? ☐YES ☐NO
IF YES DID THIS ACCIDENT OCCUR AT WORK? ☐YES ☐NO

EMERGENCY INFORMATION

IN CASE OF EMERGENCY NOTIFY NAME	RELATIONSHIP	PHONE

ADDRESS Street City State Zip

PERSON FINANCIALLY RESPONSIBLE FACCOUNT

If person responsible for payment is different from patient, then complete below.
If patient is a minor please indicate if parents are : ☐Married ☐Separated ☐Divorced

NAME RELATIONSHIP TO PATIENT	SOCIAL SECURITY NUMBER	DATE OF BIRTH

ADDRESS PHONE NUMBER

EMPLOYER NAME and ADDRESS PHONE NUMBER

REFERRAL INFORMATION

PRIMARY CARE PHYSICIAN (PCP)	NAME OF REFERRING PHYSICIAN/FACILITY/URGENT CARE/OTHER (IF DIFFERENT THAN PCP)
PHONE NUMBER	PHONE NUMBER

INSURANCE INFORMATION

DO YOU HAVE INSURANCE ☐YES ☐NO **ARE YOU SELF PAY? ☐YES ☐NO**

PRIMARY INSURANCE: ID#	**SECONDARY INSURANCE:** **ID#**
GROUP # **GROUP NAME** **EFFECTIVE DATE**	**GROUP #** **GROUP NAME** **EFFECTIVE DATE**
PRIMARY INSURANCE ADDRESS	**SECONDARY INSURANCE ADDRESS:**
POLICY HOLDER NAME **SOCIAL SECURITY #**	**POLICY HOLDER NAME** **SOCIAL SECURITY #**
DATE OF BIRTH **RELATIONSHIP TO PATIENT**	**DATE OF BIRTH** **RELATIONSHIP TO PATIENT**
EMPLOYER **PHONE NUMBER**	**EMPLOYER** **PHONE NUMBER**
EMPLOYER ADDRESS	**EMPLOYER ADDRESS**
PRIMARY INSURANCE DOES REQUIRE PRIOR AUTHORIZATION TO SEE A SPECIALIST? ☐YES ☐NO	**SECONDARY INSURANCE DOES REQUIRE PRIOR AUTHORIZATION TO SEE A SPECIALIST? ☐YES ☐NO**

I present myself or a child for whom I accept responsibility; recognizing the need for care to any and all services as ordered by my physician and agreed to by me. These services include, but are not limited to, laboratory tests, medical or surgical treatment, examination, and other services rendered under specific instructions of my physician.

_____ _____ _____

PATIENT NAME (PLEASE PRINT) **SIGNATURE (PATIENT/PARENT OR LEGAL GUARDIAN)** **DATE**